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ABSTRACT

The Family Developmental Center is a program of infant day care which during its four years of operation, has provided supportive and educational services for 82 adolescent mothers and their infants in San Francisco. This report describes the organization and development of the nursery facility, with its individualized infant stimulation programs; the weekly involvement of the mothers in the center (including care of their own and other children); parent counseling and parent group meetings; and other supportive services. Mothers accepted in the program had to agree to complete high school or a vocational program. A longitudinal study was conducted with 24 babies from infancy through 24 months of age. Infants in the center appeared to be functioning within the normal range or better in a number of areas of basic developmental importance. Psychological test data on parents indicated that the adolescent mothers had somewhat below average scores on intelligence, but felt competent and capable in their maternal role. Female teachers in the center were found to be confident, dominant, and spontaneous, male teachers more empathetic and affiliative. (GO)

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FINAL REPORT
FAMILY DEVELOPMENTAL CENTER
A DEMONSTRATION PROJECT

Judith Lewis
Project Director

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FAMILY DEVELOPMENTAL CENTER OF THE FAMILY SERVICE AGENCY OF SAN FRANCISCO

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FAMILY DEVELOPMENTAL CENTER

A Demonstration Project

FINAL REPORT

June, 1975

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OVERVIEW

The Family Developmental Center of the Family Service Agency of San Francisco deals with meeting the needs of a rapidly growing segment of the nation's population--teenage parents and their young children. Funded by the Office of Child Development in 1971 as a four year research and demonstration project, the Center is continuing to operate after the period of federal funding through a contract with the San Francisco Unified School District and a new grant from the Office of Education.

Over 210,000 school-age girls give birth each year and their numbers are increasing by about 3,000 annually. Eighty-five percent of them keep the baby rather than give it up for adoption (Howard, 1972; Jenstrom & Williams, 1975); the odds are six in ten that those under sixteen years of age will have another child while still of school age (Webb, 1973). While little is known about the later development of infants of adolescent parents, a number of factors known to influence infant growth and development have led to at least a temporary "at risk" labeling of the infants of school-age parents (Jenstrom & Williams, 1975).

Without a high school diploma and marketable job skills, the young mother's chances of ever entering the job market are extremely poor. She finds herself unprepared for the responsibilities and confinements which the role of parent entails, and with inadequate emotional support and absence of instruction regarding the needs of her infant, her own needs both as adolescent and as a mother tend to go unmet. The Family Developmental Center provides opportunities for personal growth and school completion, making it possible to become independent of the welfare system by becoming high school and college graduates and wage earners.

Free quality infant day care is provided so that the young mothers can continue their schooling. Counseling focuses on continuing education, career and job counseling. A parent education component for which the girl can receive five units of credit relates to the problems and concerns of the adolescent period as well as to the issues that are involved in childrearing.

During the demonstration project each family accepted into the program included a mother between the ages of 14 and 18 and a first born infant between two weeks and nine months of age. The mothers had to be committed to the completion of an educational or vocational training program and have a minimum of one year remaining in a defined program of study. They had to be willing to spend five hours per week participating in a parent program which included care of their own and other children, a weekly parent meeting and research aspects of the project which included developmental examinations of the infants at three month intervals and

their own assessments of themselves and their infants. The children remained in the Center until two years of age as long as the mother maintained her eligibility status.

Good nutrition is stressed in the Center program and breakfast, lunch and morning and afternoon snacks are served. Each child is cared for by one particular teacher. A ratio of no more than one teacher to four children is maintained. Since the overall nursery operation is supervised by a registered nurse, sick children with non-contagious illnesses are admitted and necessary medications are administered.

The Center is housed in the Far West Center for Educational Development at 1855 Folsom Street in the Mission area of the city. The space was designed during renovation stages as an infant center and is ideally suited for that purpose. It operates from 7:30 a.m. until 5:00 p.m., Monday through Friday and is licensed for 30 children.

SUMMARY OF PROGRESS TOWARD THE ACHIEVEMENT OF THE ORIGINALLY STATED AIMS

The originally stated goals of the Family Developmental Center project were:

A. to provide a nurturing and appropriately stimulating day care center for the infants which would foster their optimal growth and development
B. to assure adequate and appropriate health care for the infants
C. to provide an educational and supportive program for the mothers which would enhance their effectiveness and competence in the parent role and strengthen the maternal-infant relationship
D. to enable the mothers to continue their high school education and so have a wide range of options for further education, vocational training or employment.

We feel that all of the originally stated objectives of the project have been very satisfactorily accomplished. An optimal day care environment has been provided for the infants, both in terms of a specially designed facility and in terms of individualized programming. The research results based on standardized developmental tests confirmed that the children as a whole were performing at age level and above in all areas of development at all ages through two years of age when they graduated from the Center.

It was originally anticipated that the young mothers in the Center would need a great deal of guidance concerning the physical care of their children. Although primary health care was never planned to be part of the Center's program, a great deal of emphasis was placed on health in the originally proposed caregiver curriculum, as well as in the outline for the parent curriculum.

It soon became apparent that our young mothers were doing a very competent job in caring for their children's physical needs. Only one mother out of the 82 mothers who participated in our program needed repeated urging to keep her child's immunizations up to date. The same mother was the only one who failed continually to keep appointments with her doctor for follow-ups after illnesses. The mothers were a consistently conscientious group in regard to the health care of their children, perhaps even more so than the general population. For this reason assuring adequate and appropriate health care for the infants was an easy job for us.

The young mothers showed a great deal of interest when first aid and health information was presented to them in two of their weekly parent meetings. The most important learning, however, took place at times when they themselves requested help or information. For example, many mothers learned how to read a thermometer and how to recognize and report the signs of illness at the times that their babies were ill. Others asked for information regarding

the treatment of minor burns, rashes or eye infections. Since babies were admitted to the Center when they were ill, there were many opportunities for the parents to observe good techniques of sick baby care and for active teaching to take place.

Some conclusions can be drawn from our experience with sick children.

1. Children were absent from the Center for reasons other than health to a much greater extent than because they were ill. Absenteeism due to illness was probably less than ten per cent.
2. Illness posed no problem as far as the care of the children in the Center was concerned. Of course, it was recognized that a sick child may need more of the teacher's time than a well child. The teachers received pre-service and in-service training in medical procedures and felt confident in their ability to deal with possible emergencies, especially since a nurse was available.
3. It was not necessary to isolate sick children. If a baby's illness was acute he was put in a quiet place in the nursery or in an enclosed activity room so that he would experience the same environment with his familiar teacher caring for him.

We have provided an educational and supportive program for the mothers which we feel has enhanced their effectiveness and competence in the parent role and which as a result has strengthened positive mother-infant relationships. Our evaluations of this objective are necessarily more subjective than in the other areas we studied. It is our feeling that some of the adolescents become more effective in their relationships with their infants and with people in general just as a function of the maturation that is occurring over time. For this reason it is difficult to separate out changes due to maturation that would have occurred anyway and changes that are due to our particular program. It is likely that positive gains are due to both factors. Certainly, the young parents, from their own reports and our observations, need emotional and cognitive supports as they are passing through this frustrating period of egocentrism into a period of responsibility for another person that requires insight and an ability to take the "role of the other." We feel through subjective evaluation that our particular model of parent education which aims toward total personal growth of the parents is an optimal method of supporting the individual's potential for effective and competent behavior with her infant and with others as well.

Year round, ten hour per day care has provided the mothers with a maximal opportunity to continue their high school, vocational and college educations regardless of many varying schedules. Educational, career and job counseling have provided many of the mothers with options which they did not even know existed. The high percentage of our program participants who have gone on to college, who have entered the work force and who have become independent of the welfare system attests to the importance of day care and support services and the success that they can help bring about.

In addition to the four original goals already stated, there has also been an additional goal of encouraging the development of similar programs by acting as a demonstration center and by providing materials, techniques and a replicable model for parent education, infant intervention and training for caregiving personnel. We feel that this last goal, a big order, has been achieved in an optimal manner. Hundreds of visitors have toured the Center during the past two years and have spent many hours in talking with the staff about the program. Many others have called or written for information. We have had active interaction with other groups and have served as participants in many workshops. In addition to this report, we have prepared four publications for public distribution which we believe will be of considerable value to the growing number of people who are setting up infant centers and operating school age parent programs. These publications are: Helping Baby Before You See A Doctor, a medical procedures manual for caregivers; Some Practical Aspects of Operating An Infant and Toddler Center; Growing With Your Baby, A Facilitator's Manual; and Growing With Your Baby, curriculum materials for use in a school age parent group.

OPERATIONAL AND ORGANIZATIONAL HISTORY

The Family Developmental Center opened in temporary quarters on the pediatric floor of St. Luke's Hospital in October, 1971, after problems arose in locating a permanent facility that could both house 50 infants and meet the strict State licensing requirements. The basic staff was hired by November and a month long pre-service training program for six caregivers was begun on November 29. The 2,000 sq. ft. St. Luke's facility was licensed for 25 children in mid-January and the first infants were accepted on January 17. By June, the temporary facility was operating at full capacity. A continuing search for a permanent site highlighted major difficulties which are relevant to infant day care generally and especially to San Francisco. The difficulties and the ways in which we coped with them are presented in a section in the Appendix.

During October, 1972, there was a change in the administration of the project and a turnover in a number of the staff positions. It had become evident to many of us early on that there were several administrative positions that were either unnecessary or which could be filled more effectively by utilizing multi-talented personnel and by combining existing positions. For this reason, the positions of the Center director and administrative assistant were eliminated. The new project director, formerly a program and research associate, assumed the overall responsibilities that had formerly belonged to the Center director and the program and research director. Another program and research associate, who was also a nurse, became health director and also took over supervision of the nursery. The third program and research associate took on the major responsibility for carrying out the developmental testing, writing the stimulation programs and collecting data from the parents.

In December, the vacant secretary's job was reclassified as administrative secretary/research assistant and filled by a person who took over the former duties of the administrative assistant and the secretary as well as the major responsibility for analyzing data. At the same time the title of "child care technician" was changed to that of "teacher" at the request of the persons filling those jobs. They felt that the former title was demeaning, mechanical and contributed to a lack of self-esteem. They felt that the term "teacher" seemed to more accurately describe a job that is concerned with the full development of each family.

On November 1, 1972, St. Luke's Hospital informed us that they would need the space that we were renting by January 1; in effect, this was an eviction notice. Almost simultaneously, they notified us that they needed one of our four nursery rooms for their pediatric patients during San Francisco's outbreak of pneumonia and flu.

A letter of appeal was written to the hospital administrators by Edward Stern, President of the Family Service Agency Board of Directors, in December. The hospital agreed to extend our stay until February 1, if definite arrangements to move were made during the month of January. A second nursery room was taken from us at that time.

The license allowing us to operate in St. Luke's Hospital was to expire on January 16, and the application for license renewal was due by December 16. In order to continue care for all of our babies and to conform to the space requirements in the state regulations, we decided to convert office space into a nursery. Everyone made adjustments in their working area. Our cook shared the bookkeeper's office which contained a window for ventilation and a door to separate the cooking area from the nursery area. Our secretary gave up her desk and moved into the research associate's office, which was already being used as a testing room, and our nurse moved into the director's office. Most of the office furniture was placed in storage.

The licensing inspector from the Department of Social Services spent the entire day on January 11, 1973 reading all the pertinent records and observing our operations. She responded positively to our program, and offered encouragement. Her comment, which accompanied our renewal license, stated, "Unfortunately, the number of your rooms has dwindled because of St. Luke's need for space. You have done remarkably well under such circumstances. Your staff is excellent, congenial and hard working."

By December we felt optimistic that we would be able to secure space in the Far West Center for Educational Development at 15th & Folsom Streets. Our application for a license at this location was submitted on December 16.

By early January, the Far West Laboratory for Educational Development had expressed a definite interest in having us as tenants. Preliminary discussions with the City and State code and license enforcement officials indicated that the space would meet their approval. The absolute minimal cost for the necessary renovation of this space was established at $49,488.70 which included architectural and engineering fees and costs.

After a letter was written by Edward Stern, Board President, to the Office of Child Development, explaining the saving that would occur over a three year period due to the rent free agreement with Far West Laboratory, a Health, Education and Welfare Council action rescinded the federal limitation of $25,000 for renovational costs and allowed us to use unexpended funds saved largely from eliminated positions for this purpose.

After these definite commitments were made, St. Luke's Hospital agreed to extend our rental agreement until the time that renovation would be completed.

The Family Developmental Center was moved from the pediatric floor at St. Luke's Hospital to the present location at 1855 Folsom Street in late April and was opened to the families on April 30, the day that the license was granted. In preparation for our impending expansion from 20 to 50 families, five new teachers began a three week pre-service training program on May 1. Admission of new families began on May 21 and continued through the summer months. We found that the summer school vacation was a particularly poor time for expansion since many of the young mothers who were interested in becoming part of our program had not enrolled in summer school. Since commitment to a school program is a requirement for admission into the program, we sometimes had to rely on promises that a mother would become enrolled in the fall. As a result, several mothers who did not enroll in school in September had to be dropped from the program when school attendance was checked in October. For this reason, we were unable to reach our projected enrollment of 50 families on schedule. By the end of October, an enrollment of 42 families had been reached. It was at this time that we received word from our project officer at the Office of Child Development to immediately begin reducing the enrollment to 24 families with a concurrent modification of the staffing pattern in order to save substantial carryover funds for the 1974-75 fiscal year. Modification of the program to meet this directive was accomplished by January, 1974.

The modification retained a teaching ladder, but reduction to a program for 24 families meant the elimination of a number of positions, most of which were teaching ones. As could be expected, the morale of the teachers became quite low, especially until decisions were made as to which persons would lose their jobs.

Our evaluation of the modified program is that the organization and operation were actually improved. This was due to the following factors.

1. The physical space of the nursery area, although minimally meeting the licensing requirements of 35 square feet per child for 50 infants was in reality far less than adequate to accomodate 50 infants and toddlers and the many staff members, parents, relatives and friends who are present in the nursery daily. The actual attendance of 24 children is ideal for an optimal use of the space.

2. We created a more optimal teacher-to-child ratio of 1 to 3.2 which means that six teachers are assigned to four children

each, with the head teacher and half time float relieving for breaks and lunches. (We previously had a 1 to 4 ratio with most of the teachers being assigned to five infants. This ratio was unsatisfactory to accomplish the full aims of our program.)

3. The decision was made that the program director, an experienced developmental tester, would perform the infant testing throughout the remainder of the project. It was far more economical in terms of both time and money to have her perform the testing in addition to her other duties, than to spend the amount of staff time which we had found necessary in the past to recruit, interview, train and supervise novice testers over a period of six or more months. Only one of the three testers trained at different times stayed with the project for as long as a year.

4. A position of parenting coordinator was created so that one person was responsible for the implementation, structuring, and documenting of the parenting program and its resultant materials; these duties were previously fragmented among several staff members.

5. The smaller operation facilitated the interaction between staff and parents and made it easier for them to relate to each other on a personal level.

DESCRIPTION OF THE FACILITY

The Family Developmental Center is located on the ground floor of the Far West Center for Educational Development at 1855 Folsom Street in the Mission District of San Francisco. The neighborhood is of a light commercial and residential character, and is served by two city bus lines. There is a parking lot on the site which accomodates both staff and parents who own cars.

The Center occupies approximately 3,000 square feet on the ground floor of the six-story brick building, is entered from the lobby and has its own emergency exit from the outside yard. Far West Laboratories, the owners of the building, occupy the two top floors; the second, third and fourth floors are as yet unoccupied. The building is of reinforced concrete construction, is completely sprinklered throughout and has smoke detection sensors, a smoke evacuation system and forced-air ventilation.

The indoor nursery area contains a large central play area of approximately 918 square feet, an enclosed sleeping room (13'x 24') and two enclosed activity rooms (11'x 24' each) for individual and small group supervised play. In the play room, low dividers provide safe areas for crawling babies and toddlers.

The entire nursery area has a floor of resilient tile and windows of tempered glass with metal frames. Two sinks and counters are located in the play area for handwashing and bottle washing and an adjoining bathroom has a toilet and a hopper for rinsing diapers.

The enclosed kitchen adjoining the nursery area is equipped with a refrigerator, electric range and double stainless-steel sink. There is a linen and diaper closet and another closet in which dirty diapers are kept for the diaper service pick-up. A storage area over the kitchen holds canned goods, formula and other articles.

The outdoor play area, directly accessible from the playroom, measures 2,365 square feet and is enclosed and shaded by an eight foot lattice. The area includes a broad cement walkway for tricycle riding and a grassy plot upon which are located a large sandbox (with cover), a specially designed climbing apparatus with attached slide and portable equipment used both indoors and out.

Cabinets with storage space for each child's belongings and outer clothing are located in the entrance hallway. Six small offices for staff use, a testing room and a staff lounge which doubles as an observation room for visitors are located adjacent to the hall area.

Two additional restrooms and five conference rooms on the ground floor outside the Center facility are also available for our use.

NURSERY ORGANIZATION

A center's method of operation is greatly influenced by the physical plant in which it operates. In October, 1971, we felt fortunate to find in St. Luke's Hospital a facility which could be readily licensed because it met all the stringent standards for infant day care. Each teacher worked alone in a small room with five babies; the absence of other adults with whom she could exchange ideas and help contributed to a feeling of isolation. The other disadvantage of this layout was the confining of toddlers to a small area with no immediately accessible outdoor play space.

In our present center, we have one very large playroom, a sleeping room and two activity rooms for quiet play. The mandated growth of the Center to a population of 50 families with 12 teachers necessitated a structure which would insure a few consistent people caring for individual babies over the ten hour day. To do this, we set up three teams consisting of a head teacher and three other teachers. Each team of 4 teachers had responsibility for 16 or 17 babies, with 5 babies being assigned to each teacher and one or two babies to each head teacher. This lighter load was necessary to free the head teacher for scheduling duties, organizational meetings and adequate supervisory time.

The head teacher relieved the members of her teams during lunches and breaks and arranged for a substitute if any teacher was ill or on vacation. She conducted team meetings to discuss the needs of individual babies and supervised the team in all aspects of their job.

For a large group of babies (42 at our maximal enrollment) occupying shared space, the team system was an absolute must to insure continuity of care. The team system meant better supervision of teachers, certainly no isolation in a small space. In fact, it was sometimes necessary to switch teachers to different teams to avoid personality clashes. However, we found that the primary responsibility for five babies, even though the team had the help of the head teacher, was too heavy a load for our teachers to consistently carry out the individual stimulation programs.

In addition, although it had appeared that the head teacher would have the opportunity to plan and supervise, in reality, because of her own assignment to one or two babies and because of the responsibility of giving general help to the team, she was usually too burdened to carry out the head teacher functions adequately.

In November, 1973, we were advised that because of anticipated budget cuts, it would be necessary for us to reduce our population to 24 families with corresponding reductions in staff. The reorganization gave us another opportunity to evaluate the team system and make the modifications we felt would improve the nursery operation.

The teacher-to-infant ratio of one to four which we had maintained in the past is the minimum required by state law. If lunches and breaks are provided by float or relief teachers who are counted in this ratio, more than four babies must be assigned to each teacher. We judged that it was of critical importance to the program to reduce the teacher-to-infant ratio in order to ensure the consistent implementation of the infant educational program.

For this reason, we revised our staffing pattern so that six teachers care for 24 babies; two teachers arrive at the Center at 7:30 a.m., two at 8:30 a.m. and two at 9:30 a.m. In addition to these six teachers caring for 4 babies each, we have a half-time float teacher who relieves for afternoon breaks and three lunches and two co-head teachers.

The a.m. head teacher opens up the Center at 7:20 a.m.. Teachers who find that it is necessary for them to be absent, call between 7:20 and 7:30 a.m. so that the head teacher can make arrangements for substitutes before the first children arrive at 7:30 a.m. The a.m. head teacher briefs and supervises the substitutes and is in charge of the Center until the administrative staff arrive at 9:30 a.m.

The p.m. head teacher arrives at 9:30 a.m. and spends her first four hours of the day in relieving for morning breaks and for lunches; the remainder of her day from 2:30 until 5:30 p.m. is spent in supervision of the nursery and in helping the parents become involved in nursery operations. She is able to do this because the primary responsibility for four babies, although very demanding, is not too great for the teachers to handle.

The co-head teachers take the major responsibility for supervising the nursery; they are under the supervision of the program director, who relates directly to each teacher in relation to the stimulation programs for the babies and their implementation. The program director is also responsible for pre-service and in-service training and for keeping a viable list of substitute teachers.

A "program meeting" is held once a week and is attended by the project director, the program director, the head teachers, the parent coordinator and the counselor. Program planning for both the parents and the infants usually takes place through the joint decision making of this group.

The importance of flexibility and openness to change on the part of supervisory personnel cannot be stressed enough. The person supervising the nursery operation must have a commitment to the principles of child development to ensure that the sheer enormity of the physical care of the babies will not obscure the function of the teachers as promoters for the enhancement of each child's growth.

SELECTION PROCEDURE FOR TEACHERS (CAREGIVERS)

In November, 1971, over 60 applications were received for the six positions of Child Care Technician. Because of the large number of applicants, group interviews were conducted with approximately eight persons in each group; one staff member served as a group leader and one as an observer and notetaker for each group.

After an explanation of the project and the job, three film clips involving scenes of both good and poor examples of group care of infants were shown without sound. These excerpts of approximately two minutes each were taken from "Person to Person in Infancy" and "Psychological Hazards in Infancy." At the end of each clip, the group was asked to comment on what they had seen. Notes were taken of all of the responses.

A series of questions involving situations that necessitated a caregiver's interaction with the child's mother were then asked of the group and notes were taken on each individual's responses.

Each applicant was then asked to complete, in writing, responses to a series of six questions relating to infant behaviors in care situations such as feeding, crying to be held and getting into things. The applicants were then seen for 15-25 minute interviews by a member of the professional staff. The interview asked for details of work history, school history, beliefs about how babies learn, characteristics of babies that they liked or disliked, some details about their own families, ideas about teenagers, contact with and knowledge of different cultures, their physical health and feelings about their own abilities to cope with situations.

The five professional staff members then discussed all of the applicants and their responses in the group and individual interviews. There was complete agreement that all except about 12 were unsuited for the job because of punitive attitudes toward child-rearing, inability to listen to or accept another person's point of view in the group interview situation, inflexible ideas that were not in accordance with the goals of the program, and authoritarian approaches to teenage mothers.

Of the list for possible consideration, the total staff could agree on only three of the candidates as being acceptable. Three others were chosen by vote; however, each of the three was considered by at least one staff member to be an unsatisfactory choice.

Of this group, four worked for longer than average periods of time - 18, 21, 14 and 42 months; two others worked for around 10 months.

Our move to a larger facility in April of 1973, with a concurrent increase in the number of families served, necessitated the hiring of six new teachers (two of whom were replacements). We

had also changed the staff structure, and recruited separately for a head teacher because of the difference in education and experience required. The regular teachers were required to have only a high school diploma and minimal experience with infants, while a head teacher position required a B.A. degree in Early Childhood Education and a year's experience in an infant or preschool program.

Between March 15 and April 1, 1973, advertisements were placed in San Francisco's largest Sunday paper, the Chronicle/Examiner, as well as in the Sun Reporter, a paper which reaches many minority people. The Human Resources Department was contacted as well as Mission Hiring Hall, the hiring facility for Mission Coalition, a community political organization.

Out of 39 inquiries for the regular teacher position, 19 were screened out by telephone as being inappropriate for the job. Twenty written applications were accepted, and four group interviews were conducted. Each applicant completed a written questionnaire giving his ideas on questions regarding child development, ways of dealing with adolescent parents and staff relationships. These answers were then discussed in the group. Clips from the movie, "Psychological Hazards in Infancy" were shown without sound and the group was asked for their opinions of the situations depicted in the film. Individual interviews were held with the Health Director/Nursery Coordinator. In addition, each applicant was asked to spend some time in the nursery, interacting with the children and staff. This was essentially the same procedure that was followed when we recruited for the original teachers.

As the applicants were narrowed to the six persons who were finally chosen, the three professionals who were present for the group sessions could strongly agree on only two. Two of the three staff members agreed on one of the others. There was no strong positive feeling about the other three chosen; they appeared to satisfactorily meet our basic requirements and we were under a strong time pressure to begin a four week long pre-service training program so that the remaining 25 babies could be entered. Only one of this group remained with the project for over a year; for most of this group the job, along with the training, was a stepping stone to other positions that paid better salaries.

As vacancies occurred in the fall of 1973, we began to give strong consideration to applicants who had worked as substitutes for us over a lengthy period of time. We knew what their work was like and how well they got along with other teachers and parents. Of the six persons who have been hired after working for a period in a substitute capacity, five are still with the project; three of these have been with the project for over two years.

EVALUATION OF SELECTION PROCEDURES FOR THE POSITION OF TEACHER

1. Although the salary, job description and educational requirements were basically the same when we recruited for teachers in November, 1971 and March, 1973, the calibre of applicant was much higher in March, 1973. The only difference in our procedure was in the name of the job, formerly "child care technician" and now "teacher". Our society affords teachers the respect they merit. To be a teacher, one needs special attributes in addition to educational background. The position of "child care technician" is more closely associated with merely the physical care of the child and so many of the applicants attracted were much less qualified to fulfill the position as it was outlined in our program.

2. Both group and individual interviews were of value. The applicant whose educational background was impressive and who was able to articulate her attributes well in an individual interview, might "take over" in a group situation and/or an intolerance for others' opinions might be revealed. Group discussions generated a wider variety of issues than would have been possible on an individual basis. Conversely, some reticent individuals needed the opportunity to express themselves outside of the group where they may have felt overwhelmed.

3. The film clips and questions related to child development were extremely informative when interviewing for the regular teacher positions, but were of less importance in the process of hiring a head teacher. All of those applicants were familiar with child development principles. When the discussions centered around staff relationships and the handling of adolescent parents, differences in attitudes were more apparent.

4. It is highly recommended that men be included in every teaching staff. Our male teachers act as good role models for the young parents, many of whom have had unhappy experiences with men in their lives. The children gain immensely from their exposure to male figures in addition to the traditional female caregivers.

5. It is highly recommended that every applicant being seriously considered for a teaching position spend as much time as possible in the nursery, so that feedback can be received from the teachers already on staff as to which people are acceptable to them, based upon the ways that they interact with them, the children and the parents. Having applicants work as substitutes so that they can actually be observed on the job is ideal.

Summary

Good screening procedures using both group and individual interviews can eliminate applicants who are bad risks because of undesirable attitudes or personality characteristics that are fairly easy to pick up. Of persons passing all of our requirements in the

interview situation, we have had only about fifty percent success in choosing persons who had consistently good work performance over a long period of time when we did not observe them on the job. Of the persons that we have hired after observing their performance as substitutes we have approximated one hundred percent success.

PRE-SERVICE TRAINING PROGRAMS

Two group pre-service training programs were held, one in November and December, 1971 and one in May, 1973; six trainees took part in the first and six trainees and a newly hired head teacher took part in the second. Both training programs used a combination of classroom sessions and nursery experience. In the first program, since no children had been enrolled, trainees visited four Bay Area infant centers and a number of nursery school centers, made observations and discussed the experience with staff afterwards. In the second program the nursery practicum took place in our own Center; each trainee was assigned to help care for two particular children for part of each day. Both training programs included experiences in caring for newborn infants at Mt. Zion and/or St. Luke's Hospital under the direction of the Health Director.

Both training programs included information about the project and its goals, the roles of the various personnel, child development information by areas and sequences of development, adolescent development, programming for infants, how to implement the stimulation programs, problems within normal development, nursery procedures, first aid, nutrition, theoretical approaches to attachment, cross cultural child rearing practices and day care in other countries, childhood ilnesses and medical management, self-concept and language development. The agenda for the May, 1973 pre-service training program is included in the Appendix.

Persons who were hired as replacements at times other than when the two group training programs were taking place, were presented with the same curriculum and training experiences on an individual basis. Since the time of the second group training program all trainees have been required to show competence in the areas of information covered, by written and/or oral examination. Proficiency on the job for a three to six month period has been a provision of passing from probationary to regular employment status.

We found that important indications of future success on the job became apparent during the training programs. Several persons who slept through many of the sessions and contributed only sporadically to the group turned out to be sluggish on the job also. It is important to look for these indications, to evaluate their impact and to be able to terminate employees who are not meeting the standards set by the end of a clearcut probationary period. This is much easier in the long run than keeping a poorly functioning caregiver on the staff while you try to help him improve his performance indefinitely to the detriment of the children assigned to his care.

IN-SERVICE EDUCATION

In-Service education has been an ongoing process that has helped the staff grow in their jobs and retain a high degree of motivation toward fulfillment of the full goals of the center. Since we are staffed with a heterogenous group of teachers who come from diverse ethnic and educational backgrounds, the in-service education program has often been individualized as are the infant and parent programs. Whereas some teachers have enjoyed and benefited from reading articles from journals and magazines, others have been reached more effectively through one-to-one discussions. Other in-service sessions are either total staff or teaching staff oriented.

The staff at all levels have ongoing contact with the staff of the other infant care centers in the area. Workshop registrations are included as a budget item for the use of all. Our medical consultant has spoken to the group once or twice during each year; there have been other guest speakers, frequently from the University of California Speakers' Bureau.

The content of any in-service education program should reflect the interests of the group as well as the current relevancy of a topic. For example, immediately after an admission of a baby who had a history of seizures, a session was held in which the causes and management of convulsions were presented and discussed.

In preparation for the admission of high risk infants to be integrated with the normal infants in the Center, an occupational therapist who works with handicapped infants gave the group valuable information on how to observe subtle motor lags or asymmetries that are often not detected during infancy. During one of these sessions she was able to give suggestions for strengthening the weak side of a baby's body to the adolescent mother. This is an example of one of the ways that we have used in-service education to benefit a maximal number of people.

In the first two or three years of our operation, in-service education topics tended to relate to general and practical information. In the final year of operation, the staff has stablized and become a more cohesive group; as this happened, personal relationships within the Center became more important. The staff as a total group participated in over 20 hours of "human effectiveness" training in communication skills with an experienced facilator as the group leader. This experience brought the staff closer and helped to create a high motivation for cooperation because of a better understanding of each other's needs. This seminar also helped the staff to communicate more effectively with the parents.

By the final year, the staff had achieved the background and experience necessary to incorporate theoretical presentations concerning child development issues into their thinking. The total

teaching staff were trained to administer and interpret the Denver Developmental Screening Test after several of them expressed a desire in this regard.

In summary, it is suggested that the needs of the administration and the needs of the teachers and other staff be clearly communicated and interpreted to each other so that all parties can develop their jobs within common goals. There should be flexibility within the administration to modify program elements if necessary in order to respond to the needs of the teachers and the total staff. In-service education should be an individualized process that each staff member sets for himself and works toward with the support of the other staff members.

One of the most frustrating problems that we have faced has involved the career needs of the caregivers. Several teachers have been able to progress to positions of head teacher, but others have few opportunities for advancement within their chosen field of work.

TRAINING UNIT ON NUTRITION

The staff has become more and more aware of the lack of knowledge of nutrition among the parents and the population in general. While discussion concerning infant feeding has always been an integral part of the pre-service training program, it was felt that more emphasis needed to be placed on nutrition in relation to the teachers' own eating habits and feelings connected with food. A training unit included in the Appendix, entitled "Nutrition and the Experience of Eating: Infant and Adult" combines information which we have used in pre-service and in-service sessions. This format has been used in a slightly different form in our parent group and has also been used when we have participated in workshops sponsored by various community groups. The unit includes exercises that are intended to involve the group in active participation; content becomes more personal and thus for meaningful for many people by the use of this method.

FILM RECOMMENDATIONS AND SOURCES

Requests for film recommendations and sources continue to be among the most frequent inquiries from visitors, especially from those whose ongoing programs incorporate an educational component. Since our Program Director has reviewed hundreds of films in the areas of child and adolescent development over the past four years in this and a former job, she has compiled a list of recommended films and their sources which we distribute to interested persons.

Most of the films made before 1964 are either obsolete, poorly made or turn people off because of their outdated material and approach. There are exceptions to this general rule. Classic films such as the Rene Spitz film, "Grief" or Margaret Mead's series on different cultural approaches to childrearing have real value, especially from a historical point of view.

Fifteen films which we selected for a film festival, which we hosted in three conference rooms of the Far West Center for Education during the week of June 25, 1973, are in our opinion among the best films that exist in the area of child development. The schedule for the film festival, descriptive comments and sources for obtaining the films are included in the Appendix. Some excellent films were omitted from the festival because they had already been seen by our staff and parents and because they are readily available locally to others; these included "Psychological Ties in Infancy" and "Person to Person in Infancy", part of a four part series produced for Headstart.

Day care people and the community at large were invited to the film festival and we received enthusiastic responses. The films were doubly utilized as part of our inservice education for the teachers and other staff.

RECORD KEEPING IN THE NURSERY

Accurate nursery records are important not only for the purpose of data collection but also as an efficient way for communication to take place. Each teacher has a clip board marked with her name and containing three forms. Each day she records pertinent information about her four children on a one page Daily Record form. This includes how they ate, times they slept, bowel movements and medications and illnesses. Another one page form contains the Stimulation Program for each baby and a third contains the teachers' notes regarding the educational activities that were carried out that day. The Stimulation Programs are interpreted to the parents by the child's teacher and by the head teacher. They are encouraged to participate in activities with their child both in the Center and at home.

Since our Center accepts sick children, a form is posted on which either the parent or teacher records medications to be given, time last given by parent and the time that our nurse should administer the medication.

In a central location in the nursery, supplies relating to minor illnesses and mishaps are kept. These include band-aids, aspirins, thermometers and the medical procedure manual. Inside the door of this "medical cabinet" are posted emergency telephone numbers. They include our medical consultant's number, the St. Luke's Hospital Emergency Room and the numbers for the Poison Control Centers in the city.

In addition to verbal communication and space on the teachers' daily record, where parents are encouraged to write instructions, a blackboard is available for information that parents want imparted to the whole staff. This information usually encompasses restrictions in their child's diet or special handling of diaper rash.

Our cook posts the weekly breakfast, lunch and snack menus on the door of the kitchen every Monday.

Each child's diet is recorded on index cards which are kept in a small file box in the nursery. This file can easily be checked by any substitute teacher or volunteer.

A large bulletin board is located in a prominent place as one enters the nursery. A daily record of the time each child enters and leaves the nursery and the time spent by each mother participating in the Center activities is kept here. Next to this time sheet is posted a list of jobs and each mother's assignment to a particular job for that week.

Copies of the record forms used in the nursery with explanations and example are included in another publication, Some Practical Aspects of Operating and Infant and Toddler Center.

CHILD HEALTH INFORMATION

In keeping with the general goals of the Center, the health component seeks to help young parents to become more confident in the assumption of responsibility for their own family's health care. For this reason, the Center, although it is set up to care for sick children, is not designed to offer primary health care. We act as a liaison between community resources and our parents who use these facilities. Our aim is to educate the parents to seek, and, if necessary, to demand adequate explanations from medical personnel. The parents receive guidance along lines of preventive medicine and help in securing services that will continue to serve them long after our Center is no longer available to them. In this way, independence is fostered and confidence in their own abilities as parents is increased.

Infant illnesses have tended to relate to the seasons. For example, flu and pneumonia are usually more prevalent in the late winter months. As an example of how infant illnesses and absences affect the Center, October, 1973, was chosen as a typical month. There was a high enrollment of 41 children at that time. No long school holiday interrupted attendance and no high incidence of infant disease was present in San Francisco during that month.

For the children enrolled in the Center during October, 1973 the absentee rate ranged from 12½% to 45% with the mean absentee rate being 28%. Fifteen per cent of the absences were reported to be due to illness, while 85% were reported to be unrelated to illness. Absences unrelated to the children's illnesses included parent illnesses and a variety of personal reasons relating to the mothers' lives. These mainly involved disruptive relationships with their own parents and their boyfriends.

For purposes of reporting, illnesses were classified as minimal or greater than minimal. Minimal illness included slight colds, diaper rashes, and minor conditions of this sort which did not require prescription medications or a doctor's care. These minimal conditions were in general the types which would ordinarily not cause the baby to stay at home and which would be accepted by all types of child care centers. Illness of a more serious nature usually involved some type of upper respiratory infection, and would not ordinarily be accepted by most child care centers. For attending children, the average incidence of minimal illness during October was 7%; of more than minimal illness 17%. Seven per cent of the total number of babies attending received some kind of prescription medication. The most frequently administered kind of medication was Ampicillin; Demitapp and Actifed were second and third.

THE PROGRAM FOR INFANTS

The program for the babies attempts to provide an optimal environment which will facilitate the growth of cognitive and personal skills. Essential to our program are the concepts of consistency and regularity in the environment, reinforcement of the child's positive functioning, and stimulation appropriate to the individual child.

The program is based on the assumption that the teacher is a developmental agent, an active participant in the learning process. She provides a rich verbal environment and an effective model for identification, and encourages initiative, thought and curiosity. She constantly shows the infant that he is important and special to her and that she cares about him as an individual. The teacher's personality, warmth, skill, sensitivity and training are all important variable which contribute to quality day care. We strongly agree with what Francis Palmer (1969) has said in reference to two-year olds: "What he is taught is not so important as the conditions under which he is taught, specifically the nature of the adult-child relationship."

In order to perform a true developmental service, the day care program has been set up to follow the following principles:

a. The program for any one particular child is totally individualized to meet his needs within the limits of the overall necessities of the program.

b. Individual attention for the babies is vital. Our program provides one teacher for every four children. We feel that with a mixed age group such as ours, containing many very young infants, a ratio of one teacher for three children is more desireable if we are to assure time for sufficient one-to-one contact to meet the emotional and physical needs for each infant and facilitate learning on a consistent daily basis.

c. The physical environment must facilitate development. The physical environment of the day care center allows the child the opportunity to develop in an atmosphere that combines freedom with safety and permits novelty of experience without excessive stress. There is space to move around freely, explore safely and experience new forms of mastery without the necessity of confinement to a small crib or pen. Sufficient outdoor play space is a must. Our children generally spend part of every clement day outdoors.

d. Each child is allowed to learn, to cope, to master in an active way. All activities carried out with the babies stress the support of the babies' own responses and active efforts.

e. Encouragement is given to the teachers to carry out "curriculum activities" as a natural and integrated part of their caregiving throughout the day.

f. The mood of the day often provides a framework for activities. On a warm day the wading pool may be filled for water play and some of the children may nap outside in the yard. When there are extra parents or volunteers to help, the toddlers may be taken on an outing to the zoo or to the park to feed the ducks.

The teachers take cues from the children about when to do things and about when they have had enough of an activity.

g. What happens to the baby at home always serves as the background for the daily activities at the Center. Sleep and feeding schedules, upsets, etc. are important and are respected. Information is exchanged daily between parents and teachers to try to insure a reasonable continuity of care practices in the Center and the home.

h. Insofar as possible, the ages of the children were mixed for the first three years of the project, so that no teacher would be responsible for all six month olds, or eventually all two year olds. We became used to this "family style" arrangement, but felt hampered by it as the children grew into toddlerhood and wanted to spend much of their time in active play together. During the last half year of the project, practically all of the babies had grown into toddlerhood. We tried a new plan of assigning three teachers to the toddler group, with each child still being assigned to a particular teacher. The group had much more flexibility, were able to go on more neighborhood outings, and benefited from many more small group activities than we had been able to furnish heretofore.

As we phased in very young babies under a school district contract, the new babies were assigned to four other teachers. Most of the teachers prefer this system of mixing the ages up to around 18 months and then providing for separate toddler groups. Interestingly, the babies adjusted well to being transferred to another teacher for the toddler program. When they were tired or wanted comfort they tended to seek out the original caregiver to cuddle against. Since our nursery exists in one big space, this is possible and we have the flexibility to accomodate these children's attachment needs. This system allows us to accomodate to the preferences of some of the teachers to work primarily with young babies or with toddlers.

INFANT STIMULATION PROGRAMS

Stimulation programs, the individualized suggestions for activities in all areas of development relevant to each baby's level of functioning, have always been an important component of the total infant program. They are used by both the teachers and the parents. Our method of writing and implementing these suggestions has evolved over time. Until April, 1973, they were written by a research associate and were based upon her interpretations of the baby's test performance along with her observations of the baby in the nursery. The suggested activities were numerous; the program was written every three months after the child's test. The research associate conferred with the mother who was usually present for the test and with the baby's teacher to interpret the test and the suggestions. Although this method provided feedback to the teacher about the child's performance on the developmental test, the rapid development of the baby made the stimulation program obsolete after four to six weeks. Teacher motivation to carry out the same activities often lagged after two or three weeks; teachers varied in their ability to supplement the activities by their own ideas.

In April, 1973, after our move to the new Center, we decided to have our Head Teachers try their hand at writing the stimulation programs under the supervision of the Research Associate and the Nursery Coordinator; we hoped to increase the observational skills of the Head Teachers and felt that this would increase their ability to direct the other teachers in carrying out the suggested activities. This system was carried out for a brief period and although it was a learning experience for the Head Teachers, this rather time consuming additional assignment turned out to be unfeasible in view of their child care duties.

When the Research Associate resigned her position in June, 1973 the Nursery Coordinator (now called Program Director) began writing the stimulation programs. They were made briefer and brought up to date every two weeks. The Program Director receives feedback from each teacher during individual bi-weekly conferences. During these meetings the teachers are asked to demonstrate their methods of implementing the program by working with the children.

The teachers add their ideas to the list when they feel a baby is ready for a particular activity. By keeping the activities current with the baby's emerging behaviors and by adding variety by the more frequent change in suggestions, teachers have more motivation to carry out the activities. We feel that this system is superior to the others we have tried. Information on designing an infant curriculum is included in another publication, Some Practical Aspects of Operating and Infant and Toddler Center.

An individualized infant program such as ours, is more difficult to administer than a more general activity oriented one in which the children engaged in such activities as art, music time or outdoor play at particular times. Success is very dependent upon the skills and sensitivity of the program planner, who must be fa-

miliar with the sequences of development and who optimally is experienced in the techniques of infant assessment. If the person who designs the curriculum is not the person who will actually use it with the baby, a great deal of skill is also needed to communicate the program ideas to the parents and caregivers.

The many advantages of a totally individualized program include the following.

1. It is focused clearly on the individual child's levels of development.
2. It takes into account individual sleeping and eating patterns, so that a child is reached when he is highly receptive to learning, rather than at an adult imposed time.
3. It emphasizes one-to-one interaction.
4. For a program in which children are in a center as long as nine or ten hours, both babies and teachers need flexibility so that levels of interest can be maintained.
5. For a program in which there are mixed age groupings, it is often difficult to schedule activities to suit all the children's schedules, so that individual programming is more feasible.

SUPPLEMENTARY HELP

Volunteer help has the potential for being either an asset or a liability. Unless volunteers are highly motivated and need a minimum amount of supervision, a day care center for infants runs the risk of exposing young children to too many new people and not receiving the expected return of help.

Although our young mothers are required to spend five hours per week participating in Center activities, much of which time is spent in the nursery, we have found that we can expect only a few mothers to be of real help other than in caring for their own babies. School age parents have most of their energies directed toward coping with the problems of their personal lives. They certainly benefit from being in the supportive environment of the Center, observing teachers as role models and learning parenting skills, but as supplementary help, their value can only be judged on an individual basis.

THE PROGRAM FOR PARENTS

The program for the parents has become more structured as it has evolved over time. Of the five hours that each mother spends in the Center each week, one hour is spent in a group meeting, while the other four hours are spent in the nursery. The head teacher posts a list of assigned jobs each week; each mother checks the list when she arrives in order to determine her assignment. On some days, she will be asked only to care for her own child and to carry out activities which are listed on his chart. As new activities are added, the head teacher will talk to the mother about them in relation to the baby's developmental growth and demonstrate them if necessary. If her baby is asleep or already involved in an activity, she may be asked to care for and carry out activities with another baby. Parents are also asked to help out with housekeeping tasks such as bottle washing and picking up toys, and putting them away at the end of the day. Parents gain from the modeling of staff and other parents, and from the comradeship that is present in the nursery.

The parents come from all areas of the city and attend many different schools. The weekly parent group helps them to get to know each other well enough to develop friendships and trust. The sharing of problems, experiences and ideas are vital to the group process. The parent group meetings are held in a room with a couch, rug, bean bag chairs which aid in providing an informal atmosphere in which the parents can relax. A wide range of teaching methods have been used in order to evaluate the productiveness of different styles. We have found that topics that are capable of eliciting group discussion and which elicit different points of view are most productive. Content for the meetings have included such diverse topics as the handling of aggression in young children, nutrition, birth control, cause and effect of actions, how to work with institutions and how to define goals and values and how to realize them. A particular emphasis is given to the importance of parental attitudes and awareness of how the child's behaviors are being shaped through the parent's actions. Topics that are related to current events in the nursery such as ways to handle a child who is biting younger children receive a more intense and widespread interest.

THE WEEKLY PARENT GROUP

One of the changes that have takenplace at FDC over the course of its operation is that the parent program, once individualized and unstructured became formalized in the form of a weekly parent meeting. The institution of a formal group or "class" was begun in 1973-74 with some reluctance, since it was generally felt by the staff that the mothers would not be receptive to a "didactic" model of education.

We tried a variety of approaches from structured lecture to unstructured discussion, and experimented with a variety of content areas, from toilet training to women's liberation. On the basis of our work, we have reached two conclusions:

1. It is not the specific content of a mother's behavior toward her infant but the way she perceives and structures her relationship with with him which should be the focus of intervention with adolescents. Most of the mothers in our group had a basic knowledge of infant care; many of them lived at home and thus had siblings or parents as role models. The emotional and cognitive processes which accompany the period of adolescent, however may be themselves incompatible with the type of childrearing which is of survival value in this culture. The early adolescent is either limited in her capacity to relate to her child reciprocally by concreteness, or she is in the throes of upheaval and change as seen in the groping and experimentation which accompany the transition to formal operations. The focus of intervention, from this point of view, should be on a young parent's general emotional and cognitive growth. The way we structure our thoughts parallels the way we structure our relationships with others, and the developmental trend is in the direction of increasing differentiation. As one grows cognitively, she experiences increased reciprocity and exchange in relationships; she is able to "take the role of the other". This is the aspect of cognition which we are concerned with when talking about parenting. Parent effectiveness increases as an adolescent moves from egocentrism in relationships to reciprocity.

2. To experience this kind of growth, the adolescent must be involved in a situation where she has an opportunity to become aware of her own thoughts and feelings and to expand upon them through interaction with others. She must have the opportunity to experience other points of view and to question her own. This can be accomplished in a variety of ways, but the following methods are ones that have beenintegrated into our facilitator's manual that accompanies the curriculum materials, Growing With Your Baby.

   a. Providing a forum for debate on issues in which all group members are encouraged to participate.
   b. Making full use of the experience of conflict in points of view between group members by having them clarify and expand upon their beliefs, attitudes and perspectives.

c. Promoting discussion of hypothetical situations. This is induced by generating discussion around moral dilemma situations in the manual's section on adult egocentrism and infant aggression.
d. Promoting discussion of fantasies about future possibilities for infant and self with a retracing of methods for attaining them.
e. Carrying out values clarification exercises involving practice in abstracting from a particular situation, thinking about alternatives, reflecting on the self.
f. Maximizing opportunities for mothers to make discoveries about their own thinking through activity rather than just dialogue around issues. For example, role-playing provides an opportunity for individuals to experiment with experiencing another's point of view. It often leads to a new awareness of unconscious thought processes, and it is an exercise which promotes reciprocity in relationship As another example, the cooperation game in this manual provides an opportunity for reflecting on the value of cooperation and of anticipating another persons' needs.

The uniqueness of this approach to education for parents is that the focus in on a mother's growth as a total person. Successful implementation requires that the group leader be able to elicit real emotional involvement on the part of group members. The manual is designed in such a way as to help her do this. Others have approached adolescent parent education using a linear model of education, one which suggests that learning occurs simply as fact is added to fact. It has been our experience, however, that parents will not be receptive to new information unless it is somehow made personally relevant and that no real learning will take place unless they are encouraged to question their own belief systems in a nonthreatening way through interaction with others.

We met with much resistance when our group was formally instituted. Many mothers were in school all day and the thought of another class didn't excite them. Others didn't feel the need for learning more about infant care. Initially, we encountered difficulty in eliciting participation, enforcing attendance, and maintaining "group order". Many of the issues we introduced seemed abstract to the mothers and unrelated to their own interests or concerns. As time passed, however, a feeling of trust and solidarity began to emerge. It became apparent that if group members were allowed to talk about their own concerns, to ventilate about their own problems, that it was always related to their infants in one way or another. Thus, increasing trust on the part of the group members and flexibility on the part of the leader were crucial variables in group formation. After this point, it was no longer difficult to present new materials or to elicit participation. This experience led us to organize our manual in such a way that a sharing of personal feelings would be engendered from the onset of group functioning.

COUNSELING/SOCIAL WORK COMPONENT

From December, 1971 through December, 1973, the Center was budgeted for a full time social worker who carried out the intake procedures for applicants, monitored the eligibility requirements of the participants, and served as counselor in relation to educational and career problems, as well as to personal problems. The social worker was also the person responsible for structuring and carrying out an educational program for the parents around parenting issues.

When we received word that our funds were being drastically cut in November, 1973, a modification of the entire staffing pattern was made necessary. One of the changes was to cut the social work component to one quarter time and to create another quarter time position of parent coordinator. The parent coordinator was given full responsibility for structuring a parent group and writing curriculum materials and a facilitator's manual. The social worker position was changed to that of counselor with the focus of the job being on intake, monitoring, and educational and career counseling. The counselor continued to be the advocate for the parents to the administration of the Center and to the school personnel.

A lot was achieved from the latter system for a minimal cost. Graduate students from the California School of Professional Psychology were used for both positions; they were paid as staff members and also received field placement credit for the experience. We found that we accomplished our total functions as a research and demonstration project more efficiently under this system although the service aspect suffered somewhat. Because of the orientation of our social workers toward alleviating human need and a lesser interest and background in child development, we found that the parent education program had tended to receive a low emphasis during the early stages of the project. The flexibility of being able to hire different individuals with different backgrounds and talents for the two different components proved to be of great value.

The parents are not an easy group with whom to work. There is a great deal of hostility among many of them toward authority figures of any type. Some parents who are trying to cooperate, according to their own point of view, do not have the same concepts of responsibility that staff members have. Most of our parents, because of their youth and backgrounds are quite different from the parent populations previously included in studies involving group infant care.

Family life for many of the mothers has been stormy and uncertain. Our work with them after they come to us is structured by what has gone before. Some have lived in foster homes, group homes, and institutions for girls with delinquent behavior. One of the latter stated that she had been kept in solitary confine-

ment because she was violent and had been considered for admittance to a State Hospital Adolescent Treatment Unit. Another mother spent time in Juvenile Hall for hitting a teacher.

It was necessary for our social worker to go to court on behalf of two mothers in order for them to be able to keep their babies; their own families were not supportive because of long term hostile relationships between mother and daughter.

Several of the mothers have had probation officers for various reasons. There has been one contact with a Parole officer concerning a father on drugs. A few of the parents have been disturbed enough to attempt suicide. One mother was shot to death by the baby's father.

Many of the mothers in our program have met with much failure and disillusionment through school and family life experience. Those who have endured gross pathology, e.g. prostitution and alcoholism, in the home, show the effects of it. In some instances aspirations were initially low, but understandably so in the light of past experience. Our work with them indicates that their basic education is generally very poor. One of the goals of the Center staff has been to raise the aspirations of the girls. They are not only expected to finish high school; they are also encouraged and helped to go on to college. The idea of going on to college is a new concept which had never been considered by many. When necessary, the social worker or counselor has gone with the girl to the college and helped her to fill out the necessary forms for application and admission. Staff members have written recommendations for admission and financial aid.

In addition to the usual tasks of counseling regarding welfare, job training, housing, emergency food, family relationships, and child development, the social worker also attempted the larger task of helping the parents to learn how to function in the world: the cause and effect of their actions, how to work with institutions, and how to define goals and realize them.

In some cases, the Center staff has taken on supportive roles which were absent in the girl's own family. When one young mother was hospitalized for hepatitis, she had fears of failing in school because no one in her family was willing or able to make arrangements for her to do her school work in the hospital. Our social worker consulted with her counselor, took homework back and forth between hospital and school and arranged for a home teacher to come to the Center and teach her there after her discharge from the hospital, since her home was too crowded to be conducive to tutoring or studying there. As a consequence, she was able to complete the semester's work satisfactorily.

In some instances, the Center has had more impact on the father than on the mother. One couple received regular counseling from the social worker over a period of many months. The wife

never really committed herself to therapy, but the husband did. Some of the unhappiness in his life centered around a job he disliked, numerous bills and a deep disappointment with his wife. When the baby was about 20 months old, the wife left the husband and our program when she moved out of the city, taking the baby with her. For a number of months, the father continued to visit the social worker for counseling, found a more stimulating job and managed to pay off all his bills. He has returned to the Center periodically to visit with the staff and to discuss ways of helping his son.

THE NEED FOR PARENT ADVOCACY

The parents often need an advocate to help them to deal with institutions effectively. Their lack of understanding of rules and regulations and the anger often felt and expressed toward authority figures, may obstruct or prevent them from obtaining services to which they are entitled. This is often the case with the Department of Social Services. The intervention of a mature person, such as the social worker, who can effectively express a problem has, in some cases, achieved benefits for the mother which she or her own family had failed to achieve by their own communications.

The Center staff has always had a good working relationship with the counselors from the six Special Service Centers of the San Francisco Unified School District for high school pregnant girls. These counselors have a genuine interest in the young mothers, have often brought groups of pregnant students to our Center to acquaint them with our facilities, and are true advocates in their behalf. The girls can remain in the Special Service Centers through the semester in which their baby is born. When the mothers return to the regular high schools, the response from school personnel is varied. Some of the high school counselors are sensitive to the mother's needs and reduce the class hours required in order to help them manage their dual roles of homemaker and student. Other counselors are not interested in these problems or too busy to take an individual interest so that the mothers who must depend upon their efforts, flounder, get bad grades, and drop out of school and, as a result, out of the Center.

Contact with other community institutions has brought some limited help for the families. The Health Department has provided milk and foods for the mothers on Welfare. For the past two Christmases, a department stores has donated toys.

A great deal of help is needed from the school counselors. The mothers have real problems in finding a time or a place to study, and school easily becomes a failing situation. Our social worker or counselor has often assisted in these dilemmas by meeting with counselors and teachers with whom the mother was having a problem. Occasionally, a mother has been helped to transfer to another school, rather than drop out of school.

Meetings each semester in which all counselors who relate to our parents are invited to the Center to meet with our staff, have helped the counselors and us to more fully understand the problems of the parents and to more effectively deal with them. In some cases, the counselor, who obviously knows little about the mother other than her name, goes away with some real insight about her as a person with particular needs. Sometimes a counselor will bring along another school staff person whom she know will be interested in knowing more about a particular girl. It has been heartening to learn that empathetic and helpful persons such as a public health nurse may intercede for a student to help her work out her problems.

ANCILLARY PARENT ACTIVITIES

In May, 1973, we heard of a local playground designer and carpenter who specializes in teaching parent groups to build their own play equipment; he furnishes the tools and teaches the prospective builders how to use them. A meeting between the designer and staff members resulted in plans to build a sandbox and crawler and toddler sized climbing equipment for the outdoor play area.

An initial meeting of the designer with the parents was held on June 5 at the home of one of the mothers. It was attended by eight mothers, three fathers, one mother's friend, the designer, and the Center social worker. The consultant showed slides of various outdoor play equipment that he had designed and that parent groups had built; he invited parent discussion, but there was very little. It was decided to build a sandbox for the children and seven people signed up to help. The sandbox was built on June 14, 1973 with the help of eleven mothers and six fathers. In addition, three mothers and one uncle helped by caring for the children in the nursery. The staff provided and cooked a spaghetti supper which ended the day.

The next project, the building of a platform with slides and climbing equipment, was more complex and involved three workdays. On the first workday, five mothers came to help; on the second day one father, two mothers and one aunt worked in the morning and a different father and mother worked in the afternoon. The last workday was scheduled for a Saturday (at the carpenter's request) and although five parents committed themselves to work, only one mother showed up. The various reasons given for the failure to appear indicated that Saturday was a bad choice because of other planned activities; it also was the same day that AFDC checks arrived in the mail.

On the whole, the carpentry project was successful. The parents became involved in working together. Some of them learned to use tools for the first time or improved their carpentry skills. They began to express their own opinions about the play equipment--its value, suitability, etc. The large parent turnout for building the sandbox, (the initial project), may have been influenced by the factors that this was a short-term project involving one commitment, was preceded by a planning meeting in a parent's home, and that the date fortunately fell during the intersession when many students were free.

In December, 1973, a Credit Union was started by the mothers and was run for about six months until they became discouraged with trying to collect the money that had been loaned. The Credit Union came about because of their lack of money; with prices going up, several mothers were always without food before the next welfare check arrived. One mother mixed milk with water to make sure her baby was full. The Credit Union helped the parents get emergency

money, learn how to budget and was a practice in operating their own business: earning, lending, collecting, and meeting payments. The fund to start the Credit Union was earned by the parent's projects. There were several cake sales, with many of the cakes being donated by staff members, and clearing a profit of $30-40 each time. A Haloween bazaar, held in a conference room across the hall from the Center, netted $200.00.

Parents have worked jointly with staff to organize several pot luck suppers.

A clothing cooperative enables mothers to bring their children's outgrown clothes to trade for bigger sizes.

As many as six parents at a time have served on the Center's Advisory Board. One parent was elected in September, 1973 to the Board of Directors of the Family Service Agency, our sponsoring agency.

DISSEMINATION AND EXCHANGE OF INFORMATION

Over the four years of our operation, many persons have expressed an interest in learning about our program. Since we moved into our permanent facility two years ago, we have had hundreds of visitors and many staff hours have been spent in sharing our experiences with them. When possible we try to see visitors in small groups so as to make the maximal use of staff time, but we have also accomodated our schedules to allow for many individual visits.

Our basic presentation includes an orientation by a staff member outlining our history, goals and program followed by a question and answer period. One or two visitors at a time are allowed to tour the nursery area to observe activities and ask more questions. A list of over 125 of the visitors and the information disseminated to them is included in the Appendix.

Questions asked us most often concern:

1. Stimulation programs for the children
2. Teacher selection and training
3. The school age parent program
4. Equipment: choice, sources and cost
5. Record keeping and forms
6. advice on caring for sick children.

As a convenient way of disseminating this type of information we have prepared materials for distribution which include a manual with related curriculum materials for use by persons conducting school age programs and a manual for use by caregiving persons concerning medical procedures for young children and a booklet for persons setting up an infant center. The latter publication lists equipment and supplies and their costs, forms for record keeping and information about designing an infant curriculum. A unit on infant and toddler feeding and nutrition which we have used in our own inservice training has also been prepared for distribution.

Staff members have spoken to many groups and participated in many workshops and conferences in order to share our experiences in infant day care and early education, health care in a group setting, our school age parent program and other related topics.

Many people have written to us from all over the nation to inquire about various elements of our program. Experience and materials have been shared with them and a number of these people will be sent copies of our final report and other written materials as they are completed.

Portions of the final report will be submitted to appropriate journals for publication and to professional organizations for presentation. A presentation of our research findings has been scheduled for presentation to the Family Service Agency Board of Directors in September, 1975.

A presentation of the Family Developmental Center program with an onsite visit has been scheduled as part of the California Alliance Concerned with School Age Parents annual meeting in November, 1975.

RESEARCH PROGRESS

SUMMARY OF RESEARCH FINDINGS

The Family Developmental Center represents a program of infant day care and supportive and educational services carried out with 82 adolescent mothers and their infants over a four-year period. The research effort was directed at evaluation of the Center program as it involved the infant and parent populations and the teaching staff.

Evaluation of psychological test data obtained with adolescent mothers and fathers proved indicative of a pattern of needs, problems and personality characteristics generally within the normal adolescent range, but with the addition of greater family responsibility and economic difficulty. Estimates of intellectual level and reading achievement revealed somewhat below average scores for the mother group as a whole, which may be largely due to cultural and socioeconomic factors. Some of the mothers' psychological needs, as adolescents, for independence, social activity and personal recognition appeared to interfere to some extent with such aspects of their role as mothers as the degree of nurturance available to the babies and the sensitivity to facilitate appropriate developmental change. Nevertheless, there was evidence that the teenage mothers as a group had a highly positive view of their infants and felt confident and capable in their maternal role, and in fact met their babies' physical needs quite adequately, especially during the early dependency period of development. Inappropriate use of the baby for ego gratification and unrealistic developmental expectations were not uncommon among the mother group. Difficulties in the mother-infant relationship became more pronounced as the child became more exploratory, autonomous and assertive. The problem areas which emerged in this relationship did not appear especially unique to adolescence, but more as an exaggeration of difficulties frequently experienced in the population at large. Implications of these observations for family-centered day care programs directed towards serving adolescent parents would seem to indicate less concern with physical care aspects of the parenting role per se and more emphasis upon developing awareness in the adolescents of both their own psychological needs and those of the baby.

The developmental test results indicated that infants enrolled in the Center appeared as a group to be functioning within the normal range or better in a number of areas considered to be of fundamental developmental importance. No significant difference in overall developmental test performance was found at any age between infants whose condition was normal at birth and those who had experienced one or more high risk birth conditions. However, while no relationship was apparent between rating of environmental risk factors and mental development in normal birth infants, a significant positive correlation was found between the rating of environmental risk and the Bayley Mental Development Index at the

ages of both 18 months and two years (but not at 12 months) for infants in the high risk birth category. A significant negative correlation between the environmental risk rating and the Bayley MDI at six months was also noted.

Evaluation of the personality characteristics and needs of teachers of infants revealed some interesting sex differences among persons attracted to and selected for this position. Female teachers were found to be more confident, dominant and spontaneous while male teachers were characteristically less assertive but more empathetic and affiliative, as well as less satisfied about their own personalities. The personality data, including a phenomenon of time-limited interest and effectiveness among some of the otherwise highly successful teachers, raise important questions concerning what this newly-emerging profession has to offer as a career and how the teacher role can be structured so as to facilitate and maintain the positive aspects of teacher/infant and teacher/staff relationships.

DESCRIPTION OF THE SAMPLE

Population

During its four years of operation, the Family Developmental Center served a total of 82 young mothers with their infants and families. This entire population, along with the teaching staff of the Center, have provided the sample for research into the varied aspects of this group day care facility for infants, which is at the same time a supportive service for teenage parents and a prototype and training ground for the establishment of other such facilities.

The mother population, as required by the project design, ranged in age from 14 to 18 years at entrance; their mean age was 16.7 years. The ethnic composition of the group was 52% Black, 26% Latino, 17% Anglo and 5% Other, which included Native American, Filipino and mixed parentage. Ten of the girls were legally married, the rest were unmarried.

The baby group was made up of 43 male and 39 female infants. They were all between one month and nine months of age upon entrance and they remained in the Center program for an average of 10½ months.

Longitudinal Sample

Twenty-four babies attended the FDC regularly from early infancy until they "graduated" at age 24 months (21 months in the case of two babies). Since all Center babies were given developmental tests at three-month intervals, the records of these 24 babies provide a valuable longitudinal sample for developmental study.

As a further item of interest, the infants' birth records showed that 11 of the 24 had been "high-risk" infants at birth; that is, they had suffered from one or more of the following conditions: prematurity greater than three weeks, low birthweight (less than 2500 g), Apgar rating of less than 7 at one or five minutes, respiratory distress, cord wound tightly around the neck, or significant complications of labor. The other 13 babies had no abnormal conditions noted at birth. The high risk group consisted of 6 males and 5 females; the normal group, 4 males and 9 females. It was noted that more high risk babies had been born to younger mothers (mean age: 15.8 years) than had the normal babies (mean maternal age: 16.9 years); this difference was significant at the 5% level.

The mothers of these 24 babies were also considered as a special subgroup, since certain variables such as maternal personality and the mother/infant relationship were to be examined in connection with the developmental progress of the children.

Characteristics of the total sample and subsamples are summarized in Table 1.

TABLE I

CHARACTERISTICS OF MOTHERS AND INFANTS IN TOTAL SAMPLE AND LONGITUDINAL SUBSAMPLE

		Total Sample (n = 82)		Longitudinal Sample (n = 24)	
Mothers					
Ethnic Background:	Black	43	52%	13	54%
	Latin	21	26%	7	29%
	Anglo	14	17%	2	8%
	Native American	2	2%	2	8%
	Filipino	1	1%	-	
	Hawaiian/Puerto Rican	1	1%	-	
Age at Entrance:	14-16	37	45%	7	29%
	17-18	45	55%	17	71%
Infants					
Sex:	Male	43	52%	10	42%
	Female	39	48%	14	58%
Age at Entrance:	0-3 months	30	37%	8	33%
	4-6 months	32	39%	9	38%
	7-9 months	20	24%	7	29%
Length of Enrollment:	0-2 months	11	13%		-
	3-5 months	17	21%		-
	6-11 months	19	23%		-
	12-24 months	35	43%	24	100%

A questionnaire concerning various aspects of the mother's life outside the Center was given early in the enrollment period and again approximately one year later. Responses to these questionnaires from the 24 mothers of infants in the longitudinal sample were examined in order to estimate the progress the girls had made in various areas.

At the time of entrance into the FDC program, 13 of the mothers (including two married girls) were living with their own paternal families; one year later, only six were still living in this situation. The two married couples had established independent homes; two girls were living alone and caring for their babies; two were living with a male in a stable relationship; and one was living with friends. The seven marriages which existed at entrance appeared to be quite stable, as did three of the unmarried "living together" relationships. The one girl who had been living alone with her baby at the time she entered the program was still unattached a year later, but she maintained contact the baby's father. The baby's father (whether husband or not) was most often listed as the "important man" in the mother's life. Most of the girls were using contraceptives, most often "the pill". Three reported no use of contraceptives, while one began and two girls discontinued use of contraceptives during the period between the two interviews.

The girls' relationship with their own parents was generally reported to be from "fair" to "excellent" on both questionnaires. Three girls got along better with father than with mother, while three others got along better with their mothers. One girl reported a continuing poor relationship with her stepmother, and one's parental relationship deteriorated from "good" to "terrible" within the year.

Like most adolescents, the mothers had a wide range of vocational goals. Several expressed a desire to work with children or with the handicapped and several wanted to become nurses. Others revealed ambitions to do secretarial or clerical work, or just have a "nice job". No one reported a desire for a career as a "wife and mother". Nine wanted to go to college, but five would be satisfied with just completing high school. Two mothers dropped out of school upon leaving the Center program, one at the 10th and one at the 12th grade level. The former (in a follow-up interview) expressed regret and a desire to return to school. All the others either graduated, some to go on to college, or achieved a grade level of progress in school.

On the early questionnaire, 19 mothers were receiving welfare payments for the child's support. Three were entirely supported by their husbands. Other sources of income reported were parents, social security benefits and NYC jobs. The later reports indicated nine who were being supported by husband's or combined husband-wife salary. Nine girls were gainfully employed at the time of the later questionnaire who had not been at the time of their entrance.

Only three girls expressed a desire not to have any more children. (One of these subsequently had a second baby after leaving the program). Most wanted more children, but not in the immediate future. When asked about their concerns in regard to the baby, nine of the young mothers originally reported that they had none. Three worried most about the baby's health and two about his development. A year later, reported concerns showed about the same distribution.

All mothers agreed that their lives would have been quite different if they had not entered the Center program.

PSYCHOLOGICAL CHARACTERISTICS OF THE ADOLESCENT PARENT GROUP

The psychological characteristics of the young mothers in the Center program were evaluated on the basis of questionnaire and interview data, behavioral observation and psychological test data. The Peabody Picture Vocabulary Test (PPVT) was used with the mothers to obtain an estimate of level of intellectual functioning which was relatively non-threatening and independent of reading level. The results obtained with the PPVT are summarized in Table II, which compares the distribution of 42 FDC mothers' IQ scores with those obtained with the original standardization group. Sixteen, or 38%, of the FDC mothers fell within the average or mid-range category (90 to 109 IQ), which is somewhat lower than the 50% expected in a normal distribution. The total group's mean IQ was 89.45, which is indicative of a slightly-below-average level of intellectual function for the group as a whole. Although 12% of our mothers received scores above the average range, a disproportionate 50% of the mother population fell below the average into the slow learner range.

Relatively high correlations of PPVT IQ scores with those derived from more detailed standard intelligence test measures such as the Wechsler or Stanford-Binet have frequently been reported for normal population samples, including adolescent students [e.g. IQ (PPVT): IQ (WISC-full scale), r=0.82; IQ (PPVT): IQ (Stanford-Binet), r=0.92; Lavitt, 1963]. However, a study which compared WISC and PPVT IQ results with groups of grade 4, 5 and 6 children of Mexican descent and Spanish-speaking background found substantially lower correlations for the bi-lingual group (r=0.52, Corwin, 1962). The evidence suggests that the combined effects of ethnic and linguistic background, socioeconomic status and school experience affect the outcome of even those tests designed to minimize such factors.

The Wide Range Achievement Test (Reading) was administered to 19 of the 22 mothers who were currently in the program during the 1974-75 year (Table III). All enrolled in grades 9 through 12 of high school or in first semester of college, the girls showed an average grade level of 9.4 in reading ability and an average delay of 2.7 grades. Eleven were reading at high school level or higher, while eight (42%) read at less than a 9th grade level (one at the second grade level) on the test. It should be borne in mind that the grade rating is an arbitrary score and may vary with promotion practices and socioeconomic levels (Jastak and Jastak, 1965).

The personality test data for our parent population has been derived from a number of sources which tap different levels of functioning and awareness. In general, our policy has been to select tests for the evaluation of both parents and teachers which are oriented primarily towards the normal range of personality characteristics and function. It was felt that these tests should be relatively non-threatening and presented in straightforward, familiar and acceptable descriptive language. This approach may

TABLE II

DISTRIBUTION OF FDC MOTHERS' INTELLIGENCE QUOTIENTS ON PEABODY PICTURE VOCABULARY TEST

Intelligence Quotients	Percentages Standardization Group n = 4,012	Percentages FDC Mothers n = 42	Classification
125 and above	5	2	very rapid learners
110 to 124	20	10	rapid learners
90 to 109	50	38	average learners
75 to 89	20	21	slow learners
below 75	5	29	very slow learners

00053

TABLE III

DISTRIBUTION OF MOTHERS' READING GRADE LEVEL AS MEASURED BY THE WIDE RANGE ACHIEVEMENT TEST

(n = 19)

GRADE LEVEL	NUMBER	PER CENT
12.0 - 12.9	5	26.3
11.0 - 11.9	4	21.0
10.0 - 10.9	1	5.3
9.0 - 9.9	1	5.3
Below 9.0	8	42.1

not permit the depth of analysis which might be afforded by greater emphasis on more projective or psychopathologically oriented test procedures. Nevertheless, we feel that these data provide a valuable source of insight into the personality characteristics of both our teacher and parent groups as well as a useful basis for comparison with established normative data on other occupational, socioeconomic and ethnic groups.

While some resistance was encountered, most mothers participated willingly in the test procedures, which may have been perceived as a sign of the Center's interest in them as individuals as well as an opportunity to express some of their personal feelings. This may be due in part to the fact that they are adolescents accustomed to a school-like situation and are in the dependent position of receiving supportive counseling as well as the other services of the Center. Many of the research aspects of the project may also have been acceptable to the parents on the basis of being considered primarily focused on their children's development.

The mean percentiles and rank order of the manifest needs measured by the Edwards Personal Preference Schedule and the Adjective Check List administered to FDC mothers are summarized in Table IV. It should be borne in mind that the norms upon which the percentile scores are based were drawn from a more adult population than our adolescent group. Grierson (1961) found little consistency between adolescents' self-rating and teachers' ratings of their behavior. However, Spearman rank order correlations between the hierarchy of needs according to the EPPS as compared with that found with the ACL in this study showed a significant positive correlation between the results of the two tests (r_s=0.66; $p<.02$, two-tailed test). The percentile means for the mothers on the EPPS ranged from 22 to 79; means on the ACL from 45 to 52. The results of the EPPS for the mother group were indicative of near average interest in achievement-related activities despite their somewhat lower score on this variable on the ACL. The variables of affiliation, nurturance, order, abasement and deference ranked low in the need hierarchy for the mothers as a group, while aggression, heterosexuality, endurance and exhibition ranked high.

The composite personality picture emerging from the ACL and EPPS results concerning the mothers is one of an assertive, socially active individual, particularly with members of the opposite sex. She is energetic, determined, demanding of attention, and has a need for independence. She also appears to be somewhat reluctant to accept the decisions of others and to accept blame or experience guilt. At this stage of development, she does not emphasize strong attachments to friends and does not appear to be a highly nurturing person. While there is considerable variation from this overall picture, these findings have important implications for the role of a family-oriented center in responding appropriately to the needs of the adolescent mother.

The Rotter Incomplete Sentences (High School Form) was used with a subsample of 43 mothers to gain an open-ended expression of

TABLE IV

MEAN PERCENTILES AND RANK ORDER OF NEEDS

OBTAINED ON THE EDWARDS PERSONAL PREFERENCE (EPPS)

SCHEDULE AND ADJECTIVE CHECK LIST (ACL)

FOR FDC MOTHERS

	EPPS (n=40)			ACL (n=41)		
MANIFEST NEED:	Rank	Mean %-ile	SD	Rank	Mean %-ile	SD
Achievement	10	47.0	3.2	15	44.8	7.7
Deference	11	36.6	3.0	8	48.6	6.6
Order	13	35.4	3.8	13	46.7	7.6
Exhibition	4	74.3	3.2	3	51.6	7.3
Autonomy	5	68.7	2.6	2	51.7	7.6
Affiliation	15	22.0	4.4	14	45.1	9.1
Intraception	7	60.0	4.4	11	47.6	7.6
Succorance	9	50.6	3.6	4	51.5	7.5
Dominance	6	65.9	3.1	9	48.2	7.0
Abasement	12	36.2	4.2	7	50.1	7.0
Nurturance	14	28.8	3.8	12	47.6	8.3
Change	8	55.8	3.4	6	50.2	8.7
Endurance	2.5	77.7	3.5	10	48.1	8.1
Heterosexuality	2.5	77.7	5.3	5	50.6	9.3
Aggression	1	79.4	3.6	1	52.4	9.5

their feelings in several areas of personal and social adjustment. The sentence completions were scored for degree of conflict, positive attitudes, as well as neutrality and omission (Table V). The sentences were rated independently on a scale from 0-6 for these dimensions by two independent examiners. The mean score obtained by the FDC mother sample of 123.0 is close to the mean of 121.1 reported for adjusted female college students by Rotter and Rafferty (1950) and well below the cutting score of 135 which these authors found to provide an efficient separation of adjusted and maladjusted students.

The responses of 20 FDC mothers, ranging in educational level from 10th grade through college sophomore, to the Mooney Problem Check List have been analyzed. This inventory is organized into eleven categories of problems, each containing 30 items. The test is administered twice to the mothers. The first set of responses indicated "troubles" while the second focuses on "real problems". The results of these two groupings of problems are ranked in Table VI and provide a contrast between those areas regarded as relatively superficial concerns and those perceived as sources of more serious conflict by our mothers. Overall, there were fewer responses to "real problems" category. There is generally close agreement with respect to the types of problems most frequently selected by mothers for both tests I and II. Items representing the areas of personal and psychological relations; health and physical development; and finances, living conditions and employment were selected most often on both the first and second tests. However, finances, living conditions and employment were ranked as the foremost "real" problem area, while personal and psychological relations ranked first in the category of "troubles". It is interesting that home and family, which ranked 4th in terms of response frequency in the "troubles" grouping, dropped to 7th place, when ranked as a "real" source of problems.

Table VII presents a comparison of the most frequently selected individual items on Test I with those of Test II. These results seem to indicate that our mothers share many of the concerns typical of adolescence despite their increased family responsibilities and other, including financial, difficulties. Many of the intense real-life problems faced by these mothers (e.g. illness, suicide, drugs, violence and prison) are not covered by the Mooney Check List, but have been described by the mothers in their own words in the less structured inquiry at the end of the test.

Mothers were asked to rate their own self-image on Gordon's How I See Myself Scale (see Appendix). They also rated their perception of their child and their own maternal role on an FDC variation based on this scale, How I See My Baby. The How I See Myself items were grouped for scoring purposes into seven categories: teacher-school, physical appearance, interpersonal adequacy, autonomy, academic, physical adequacy and emotions. Group mean self-perception scores obtained from the 24 mothers in the longitudinal sample group are summarized in Table VIII. Mean

TABLE V

DISTRIBUTION OF POSITIVE AND CONFLICT RESPONSES IN ROTTER SENTENCE COMPLETIONS OF FDC MOTHERS (n = 43)

	Number of Responses	Per Cent
Positive 3 (high)	61	4
Positive 2 (medium)	224	13
Positive 1 (low)	275	16
Neutral	398	23
Conflict 1 (low)	288	17
Conflict 2 (medium)	296	17
Conflict 3 (high)	115	7
Omissions	56	3

TABLE VI

MOONEY PROBLEM CHECKLIST: ORDER OF IMPORTANCE OF 11 PROBLEM AREAS BY SELF-REPORT OF FDC MOTHERS
(n = 20)

Problem Area:	"Troubles"		"Real Problems"	
	Rank	Frequency	Rank	Frequency
Personal-psychological relations	1	140	2	50
Health, physical development	2	135	3	49
Finances, living conditions, employment	3	129	1	52
Home and family	4.5	120	7	32
Adjustment to school work	4.5	120	4	47
Social & recreational activities	6	112	9	23
Social-psychological relations	7	93	10	22
Vocational & educational future	8	92	6	37
Morals & religion	9	88	8	27
Curriculum & teaching procedure	10	86	11	15
Courtship, sex & marriage	11	73	5	38

TABLE VII

MOONEY PROBLEM CHECKLIST: ITEMS MOST FREQUENTLY CHOSEN BY FDC MOTHERS AS (I) TROUBLES AND (II) REAL PROBLEMS

Test I

Item No.	"Troubles"	No. Responses
30	Worrying	12
2	Being overweight	11
5	Tiring very easily	11
50	Not spending enough time in study	11
3	Not getting enough exercise	10
113	Not getting enough sleep	10
116	Wanting to earn some of my own money	10
286	Too little chance to do what I want	10
83	Forgetting things	10

Test II

Item No.	"Real Problems"	No. Responses
50	Not spending enough time in study	7
2	Being overweight	7
5	Tiring very easily	6
116	Wanting to earn some of my own money	6
30	Worrying	6
46	Missing too many days of school	6
111	Not as strong and healthy as I should be	5
64	Having to watch every penny I spend	5

TABLE VIII

HOW I SEE MYSELF SCALE: MEAN SCORES* OF MOTHERS IN LONGITUDINAL SAMPLE GROUP FOR SEVEN CATEGORIES OF SELF-IMAGE

	Teacher-School	Physical Appearance	Interpersonal Adequacy	Autonomy	Academic	Physical Adequacy	Emotions
$\bar{X}$	3.67	3.29	3.54	3.05	3.52	3.65	3.21
SD	0.74	0.82	0.63	0.55	0.72	0.80	0.93
Rank	1	5	3	7	4	2	6

* Scale: 1 (negative) to 5 (positive)

00061

scores were all in the positive range (greater than 3, on a scale of 1-5), with the most highly positive self-evaluation in the teacher-school category and the least positive in the autonomy category. Total positivity scores ranged from 60-100%.

Items on the How I See My Baby scale were considered as either mother-centered (e.g., "Handling baby is easy for me") or baby-centered (e.g., "My baby is smarter than other babies"). Responses showed 81% positivity on mother-centered items and 82% positivity on baby-centered items, generally indicating a high degree of optimism and confidence in their view of their offspring as well as of themselves in the parenting role.

Fourteen mothers repeated the How I See Myself and How I See My Baby evaluations after spending approximately one year in the FDC program. Although half of the scores on both tests were more highly positive at the second administration, an equal number were less positive, and differences were too small to create any discernable difference for the group as a whole.

Mother-Child Interaction

The mothers' responses to their children's physical, cognitive and emotional needs were rated from notes kept during their participation in the project. The principal source of information was observations concerning mother/child interaction made by the examiner at the time of the developmental tests, given at 3 month intervals. This notekeeping method was elaborated over time to cover specific areas and a rating scale of mother behaviors and teaching styles was developed and used. Notes from the Health Director's files were also used. Each rating was made by the developmental tester who had made the largest number of the observations and notes for the period being rated. When no specific observations were noted or incomplete notes existed, no ratings were made.

Three sets of ratings were made, covering each of three periods of development: the dependency stage, birth to the beginning of crawling; the exploratory stage, crawling to toddlerhood; and the autonomous stage beginning with toddlerhood and the emergence of negativistic behavior. Generally, the dependency stage covered the period from birth to around seven months, the exploratory stage ranged from seven to around fifteen months, and the autonomous stage from around fifteen months until the child left the Center at two years of age.

Fourteen mothers were rated for the dependency period, fourteen for the exploratory period, and seventeen for the autonomy period. The scale items and group means for response to the child's physical, cognitive, and emotional needs for each of the three developmental periods are given in Table IX. The group means were highest for response to physical needs across all developmental periods. Response to cognitive needs was lowest and response

TABLE IX

MEAN RATINGS* OF MOTHER/CHILD INTERACTION

DURING 3 DEVELOPMENTAL PERIODS FOR

LONGITUDINAL SUBSAMPLE (n = 24)

Scale 1 (negative response) to 5 (positive response)			Mean Rating		
			Dependency Period	Exploratory Period	Autonomy Period
PHYSICAL NEEDS (feeding, cleanliness, health care):					
Provides inappropriate care or no care	vs.	Provides very appropriate and consistent care	3.5	3.4	3.6
COGNITIVE NEEDS (in test and other learning situations):					
Hinders learning by unfavorable teaching style	vs.	Facilitates learning by helpful teaching style	3.3	2.6	2.6
Fails to provide toys and experiences, or provides inappropriately	vs.	Provides toys and experiences sensitively and appropriately	3.1	2.3	2.6
Provides no guidance or help toward success	vs.	Helps by arranging toys & environment so baby has better opportunity to succeed	2.4	2.7	2.8
Provided no verbal interaction	vs.	Provides much verbal interaction	2.2	2.5	2.6
Punishes exploratory behavior	vs.	Facilitates exploratory behavior	-	2.9	3.0
Mother's presence has adverse effect on baby's test performance	vs.	Mother's presence has positive effect on baby's test performance	-	3.7	3.0
EMOTIONAL NEEDS:					
Is very impatient in relating to baby's needs	vs.	Is extremely patient in relating to baby's needs	4.0	3.5	3.4
Mother's actions elicit distrust or no trust in baby	vs.	Mother's actions elicit high degree of trust	3.4	3.3	3.2
Is very anxious or insecure in relation to baby's care	vs.	Is highly confident in relation to baby's care	3.3	3.5	3.3
Is highly controlling of baby's actions	vs.	Allows baby freedom of action and choice	3.2	3.1	2.9

TABLE IX (Continued)

MEAN RATINGS* OF MOTHER/CHILD INTERACTION

DURING 3 DEVELOPMENTAL PERIODS FOR

LONGITUDINAL SUBSAMPLE (n = 24)

			Mean Rating		
			Dependency Period	Exploratory Period	Autonomy Period
EMOTIONAL NEEDS (Continued)					
Is rough in handling of baby	vs.	Is especially tender in handling of baby	3.1	3.0	3.0
Gives no evidence of enjoyment of baby	vs.	Shows high degree of sustained enjoyment	3.1	3.2	3.1
Displays highly unrealistic expectations for baby's development	vs.	Displays highly realistic expectations	2.9	3.0	3.1
Gives little or no evidence of affection	vs.	Gives extravagant display of affection (kissing, hugging, cuddling, etc.)	1.4	1.3	1.5
Makes frequent disparaging remarks about child	vs.	Frequently praises child	-	3.0	3.0
Negative response to child's undesirable action*	vs.	No negative response; modifies situation*	-	3.0	3.2

* Scoring for this item:

1 = Three or more negative responses such as "yells", "slaps", "grabs away roughly"

2 = Two negative responses such as "slight slap on hand" or "threatens in sharp voice"

3 = One negative response such as yelling, admonishing, slap on hands

4 = No negative responses, but does not distract child or modify situation (Example: verbal instruction while restraining child's hands)

5 = No negative response, also distracts child and modifies situation

to emotional needs fell between physical and cognitive needs across all periods. There was observable (but not statistically significant) change from period to period within each category of need.

Responses to the baby's physical needs were average or better during all periods. The mothers as a group seemed neither to hinder nor to facilitate learning in the test or other learning situations. They provided toys and experience in response to cognitive needs to a satisfactory degree during the dependency and autonomy periods, but were less adequate in this respect during the exploratory period. The mothers were more likely to provide rattles or mobiles and provide for large muscle activities for toddlers than to show awareness for the need for manipulative toys, books, and fine motor experiences for exploratory age babies. They were moderately helpful and guiding in modifying the baby's environment so that he had an opportunity to succeed in learning situations during the exploratory and autonomy periods, but during the dependency period, they were less likely to think about the importance of positioning the baby for success in looking and in reaching.

The mothers interacted with the babies verbally to a moderate extent in the exploratory and autonomy periods, but talked to the babies less in the dependency period. Some mothers commented that they did not talk to their babies because they felt that the babies did not respond or would not understand them.

Mothers as a group neither punished nor facilitated exploratory behavior in learning situations in either the exploratory or autonomy periods. The mother's presence was a positive factor in relation to the baby's test performance when evidences of attachment were at a peak during the exploratory period, but had neither a positive or negative effect during the autonomy period. These factors were not rated for the dependency period.

The mothers as a group were rated as being average or slightly higher in patience in relation to the babies' needs during all periods. They displayed an average degree of confidence about relating to the baby's care and appeared somewhat more confident during the exploratory period. Across all three periods, it was judged that a moderate amount of trust was elicited in the baby by the mother's actions, that the mothers were moderately controlling or allowing of the babies' actions, that they were neither rough nor particularly tender, they showed a moderate degree of enjoyment of the babies, and were moderately realistic in regard to their expectations for the babies' development.

There were very few evidences of affection displayed by kissing, hugging, or cuddling during any period. The mothers tended to neither make disparaging remarks nor praise the children profusely. The most common response by the mother when the child did something that she did not want him to do was either to admonish him or to slap him on the hands.

The mothers presented a group picture of neither hindering nor helping the children in their development across all of the age periods. They tended to take very good physical care of the children, and were quite patient, especially at the earlier ages but showed few signs of physical affection such as kissing or cuddling. They had a tendency to not talk very much to the babies until they were eight or nine months old, but at this time the babies showed evidences of good attachment to the mothers and the quality of their play was better when the mother was present. This reaction disappeared when the children progressed into the autonomy period.

As a group, the mothers appeared to be functioning above average in regard to the physical care of their children. Response to emotional needs appeared average and the response to cognitive needs were approximately average.

Individual patterns of response were noted. Only one mother was consistently given ratings above the mean across all categories of response for all periods. No mother was consistently rated below the group mean for all categories and all periods, according to the available data. The mothers as a group showed fairly consistent patterns of response over time although a few were observed to cope less well with the child's cognitive and emotional needs as he passed through the exploratory into the autonomy period. Examples of the notes from which ratings were made from each of the three developmental periods are included in the Appendix.

Fathers of FDC Babies

A number of fathers were familiar figures in the nursery and their presence was welcomed by the staff and, of course, the babies. Some were not actually the father of the baby, but were the mother's current steady boyfriend acting in this capacity. A survey concerning fathers of the 24 babies in the longitudinal study showed that 18 of them often delivered or picked up the baby, or came with the mother at these times. Nine of these fathers, however, became uninvolved with the baby's mother during the enrollment period and no longer appeared.

Four fathers sometimes came to the Center without the mother to see or play with the baby. Two had active interaction with the staff, including topics other than the baby's care, and some interaction with eleven others was reported. Nine fathers participated to some degree in the activities of the Center, three of them quite actively. Activities which had the most father participation were: helping to build outdoor play equipment, attending parent meetings, and watching movies made of the Center babies.

The Edwards Personal Preference Schedule and the Adjective Check List were administered to eight fathers who were often present in the nursery. The young men ranged in age from 18 to 23 years. Although the group as a sample was too small to permit generalization, they presented on the whole a picture similar to that of the mothers in relatively high need for aggression, autonomy, exhibition and heterosexuality, while showing relatively low need for order, affiliation and deference. They appeared to differ noticeably from the mothers, however, in their higher need for achievement and for nurturance; this suggests that the father member of the young family group may be more directive and controlling on the interpersonal scene, which is in line with general observation and experience in the program.

MOTHERS' PROGRESS IN THE PROGRAM

Attrition

In view of the age group and background of the population, it was expected that there would be a relatively high attrition rate among mothers and babies enrolled in the FDC program. Experience showed that of the total enrollment of 82 families, 28 (34%) dropped out during the first six months of enrollment; an additional 17 (21%) dropped out before completing a full year. Of those 28 who dropped out in the first six months, most had poor school attendance and also dropped out of school. Reasons were: illness of mother or baby, availability of other more convenient child care arrangements, decision not to continue in school, desire to stay at home with the baby, a move out of the city or the country, and personal problems which made school attendance unfeasible. Only four of this group had any further contact with the Center after they terminated. None finished school while in the Center program.

A larger percentage of the Anglo (43%) and Latino (38%) enrollment than Black (33.3%) mothers dropped out of the program (and usually out of school) during the first six months. Expressed positively, 67 percent of the Black, 62 percent of the Latino and 57 percent of the Anglo girls remained in the program for six months or more. 52 percent of the original Latino enrollees remained in the program for 12 months or more while the number of Black girls who remained for 12 months or more dropped to 47% and the number of Anglo girls dropped sharply to 21% of the original enrollees for that race.

Attention is called to the stresses that exist in the lives of the young mothers immediately following the baby's birth. Of the 28 who dropped out soon after entering the program, most had very young babies. Many found it just too difficult to continue in school and at the same time deal with their own health problems, the health condition of their infant, their feelings about being away from their baby for a large part of the day and the multiple problems of daily living. Many of the girls who dropped out early had problems with their own parents and little or no support from them. Some experienced rejection by their families; this was particularly true for several of the Anglo girls. The Black families as a whole seemed to be more supportive of the young mothers, to give them more help; Black grandparents were seen more often at the Center than grandparents from any of the other ethnic groups.

School Progress

Of the mothers who attended the program for 6 months or more, 38% of the Black and 38% of the Anglo girls graduated from high school; 46% of the Latino girls and both of the Native American mothers graduated. In all the racial groups one or two girls were continuing in school at the time that their child

reached the upper age limit for the infant program and graduated. Of the six Latino high school graduates, five went on to college. Seven of the eleven Black high school graduates attended college as did one of the three Anglo high school graduates. Neither of the Native American high school graduates entered college, but one of them enrolled in an Adult School at night in order to take science courses that she needed to enroll in Nurse's Training.

Girls who used the Center's services and thus stayed in school for at least 6 months showed about a 50% success in graduating from high school, as compared to none known to have graduated without the Center's services.

Latino dropouts from the program occurred primarily in the first six months of enrollment; 11 of the 13 who continued remained in the program for 12 months or more. Six graduated from high school and five went on to college. The Black mothers, on the other hand, showed approximately as high (30%) a dropout rate after 6 months in the program as before. The Anglo mothers showed an even higher dropout rate (63%) after 6 months; only 21% of the original group continued with the program for 12 months or more. For the total group of mothers, 60-70% of those in the program for 12 months or more graduated or are expected to graduate from high school. Thirteen of 22 or 59% of those who graduated from high school went on to college. Almost none of these had considered attending college before entering the Family Developmental Center program. It is interesting to note that most of these girls hope to obtain degrees in order to work in such helping professions as medicine, social work, child psychology, mental retardation and nursing. We conclude from these results that the first year is indeed the hardest for the school age mother. The Anglo mothers as a group appeared to have more stresses, fewer supports, and less success in coping with their problems and school at the same time; their dropout rate was highest for any of the ethnic groups for the whole first year of the baby's life. Many of the Black mothers' need for support and motivation for school remained high especially through the first year. The Latino group appeared to cope better and have higher motivation for school; individuals from this group, however, were just as needy of support services as individuals from the other groups.

Of the 52 mothers who continued with the program for over six months, seven became pregnant and decided to keep a second baby; one of these was Hawaiian/Puerto Rican and the remaining six were Black. Of these, two graduated while pregnant, two are continuing with school and have placed the second child with the FDC program*; three pregnant mothers dropped out during the second pregnancy. Six others had second babies after they left our program; three of these were Black, two were Latino and one was Anglo. 24% of the total group had a second baby while the project was still in operation; more Black girls chose to have a second baby than any other group. A number of mothers had abortions rather than have a second child; we do not have accurate figures since this information was sometimes kept secret or revealed through gossip.

*Under separate funding by the San Francisco Unified School District

Continuing Contact With Dropouts From the Program

Eleven families were enrolled in the program for a period of less than three months, six of them for one month or less. There was no further contact with the Center for any of these families after termination.

Seventeen families participated in the program for periods of from three to five months. Four of these mothers had some contact with the Center after termination. Two of them came in once to visit and to show photographs of the family. One gave a picture of the baby to a staff member. Another baby, whose mother had been killed while in the program, was brought in by an aunt for a party on his first birthday. A fourth mother, who had dropped out of school, came in over a period of several months to volunteer her services in childcare activities in the nursery. There has been no contact from any of these mothers in the past 1½ to 2 years.

Of 18 mothers who were enrolled in the program from six to twelve months, 11 have initiated contact with center staff after termination. Two of these called the social worker or the nursery coordinator to talk about personal events in their own lives. Five either called or made a visit to the Center to obtain help in entering their child in a nursery or child care center; two of these asked if they could be readmitted to the Center. Four came in for social visits with the staff; three of these came on repeated occasions and are continuing to have contact with the Center. One has called frequently to share information about her life and has additionally brought in outgrown baby clothes for use by other mothers.

Nine families dropped out of the program after they had been enrolled for at least 12 months. Four of these had no further contact with the Center. Of the five parents who had subsequent contact with the Center, four came in for social visits with the staff; three of these came on repeated occasions and one, a father, continued in family counseling with the social worker for a period of several months. One mother called for help in getting her child admitted to a child care center. Two of the contacts of this group have been recent.

Summary

Of 28 families who participated in the Center program for less than 6 months, only 4 (or 14%) had any further contact after termination. Only one of these mothers made repeated contacts with the Center; she volunteered to help in the nursery for a period of several months.

Of 27 families who were enrolled in the program for six months or more before dropping out, 16 (or 59%) had subsequent contact with the Center. Six of these wanted help with child care arrangements. Eight came in for social visits with the staff and to show how the child had grown and progressed. Two called to talk with staff members about personal matters.

DEVELOPMENTAL PROGRESS OF FDC INFANTS

Immediately preceding entrance into the Center, each child was administered the Bayley Scales of Infant Mental and Motor Development. Thereafter, this test was readministered at the ages of 3, 6, 9, 12, 15, 18, 21 and 24 months. A Bayley Infant Behavior Profile was also recorded after every test to examine each child's behavioral pattern. At 21 and 24 months, the Merrill-Palmer Scale of Mental Tests and the Peabody Picture Vocabulary Test were also administered, and at the age of two years, the Stanford-Binet Intelligence Scale (Form L-M) was administered. A limited amount of follow-up developmental test data at the ages of 2½, 3 and 3½ years has also been collected.

The mean Bayley developmental indices obtained at different ages on the mental and motor scales for both the total infant sample (n=82) and the longitudinal subsample (n=24) are summarized in Table X. Both groups appear to show similar trends, with mean test scores ranging from average to slightly above average over the two-year period, and do not differ significantly from each other.

In our approach to the assessment of infant behavioral development we have sought to go beyond overall developmental mental and motor quotients to obtain greater specificity regarding individual patterns of strength and vulnerability. One example of this approach has been the use of 9 sub-scales based on the Bayley Scale of Infant Development as follows: *

1. Sensory Responsiveness and Orientation
   Orienting response to direct presentation of visual, auditory and tactile stimulation. Includes visual and auditory following and search.

2. Gross Motor Development
   Large muscle control: coordination, balance and mobility of head, trunk, arms and legs.

3. Fine Motor Development
   Manipulative dexterity, eye-hand coordination and perceptual motor skills.

4. Exploratory Drive
   Self-initiated exploration of environment visually and through reaching out to examine and exploit characteristics of surrounding stimulus objects.

5. Competence Motivation
   Purposefulness, sustained effort and appropriate task orientation in problem solving. Persistent striving for mastery and completion.

*This method of analysis was presented by A. Lodge at a symposium entitled "Innovations in the Assessment of Infant Behavior", as part of the Meetings of the Western Psychological Association, Anaheim, California, April, 1973.

TABLE X

MEAN BAYLEY DEVELOPMENTAL INDICES AT DIFFERENT AGES FOR THE TOTAL INFANT SAMPLE (n=82) AND LONGITUDINAL SUBSAMPLE (n=24)

		Total Sample		Longitudinal Sample	
		MDI*	PDI**	MDI*	PDI**
3 months (2.5-3.5)	$\bar{x}$	107.23	119.54	112.13	115.73
	SD	14.59	16.39	15.82	14.16
	n	26	26	15	15
6 months (5-7)	$\bar{x}$	119.73	112.16	116.71	108.47
	SD	15.89	9.49	13.38	9.91
	n	56	56	17	17
9 months	$\bar{x}$	122.58	110.92	120.35	107.43
	SD	13.55	16.26	14.19	15.72
	n	60	60	23	23
12 months	$\bar{x}$	113.51	113.47	112.71	115.48
	SD	13.54	17.49	13.89	17.22
	n	43	43	21	21
15 months	$\bar{x}$	115.67	111.82	116.14	113.24
	SD	8.29	9.71	8.37	9.40
	n	33	33	21	21
18 months	$\bar{x}$	109.32	110.64	109.75	111.42
	SD	11.08	14.02	11.78	14.26
	n	28	28	24	24
21 months	$\bar{x}$	109.48	114.13	109.48	114.13
	SD	15.16	10.86	15.16	10.86
	n	23	23	23	23
24 months	$\bar{x}$	108.26	112.05	108.26	112.05
	SD	12.59	8.80	12.59	8.80
	n	19	19	19	19

* MDI: Mental Development Index
** PDI: Psychomotor Development Index

6. Social Relatedness
   Nonverbal responsiveness and adjustment to interpersonal stimulation, relating through facial expression, gesture and play.

7. Imitation
   Imitative matching of behavior in a social situation and ability to learn from demonstration.

8. Perceptuocognitive Development
   Perceptual discriminations, learned associations, and emergent concepts. Insightful problem-solving through appreciation of spatial and causal relationships as well as object constancy.

9. Language Development
   Vocalization, verbal comprehension, expressive use of language.

Use of this method results in a descriptive profile based on mean developmental age equivalents for the items involved derived from established normative data. This approach differs from the short term statistical groupings of interrelated items offered by factor or cluster analysis in that the behavior categories have been selected on the basis of their face validity, observed clinical relevance and continuity over time. Characteristic developmental test profiles appear to differentiate among infants with a variety of high-risk and retarding conditions of environmental as well as organic origin. (Lodge, 1968; Lodge and Kleinfeld, 1973). In addition to its theoretical significance, such information helps to provide a specific basis for prescribing and monitoring the effects of therapeutic and educational intervention.

Table XI describes the Bayley developmental performance profiles in terms of group mean developmental age equivalents for various areas of performance of 6-month-old infants enrolled in the Family Developmental Center program for three months or more compared with those of a comparable group of 6-month-old infants who have not had day care experience, as well as two similar groups at 9 months of age. Examination of the Center infants' developmental test profiles at both ages indicates that as a group they appear to be performing within the average range or higher in all areas. No significant differences were found between performances of day care center babies and home-reared babies at either age.

Progress of Infants in the Longitudinal Group

Table XII presents developmental test scores on a number of measures obtained with the longitudinal sample of 24 infants at the time of their "graduation" from the Center at two years of age. These results indicate overall developmental progress within the normal range, with a mean Bayley Mental Development Index (MDI) of 108 and a slightly higher Bayley Psychomotor Development Index (PDI) of 112 for the group. The graduates obtained a mean Mental Age score of 26.6 (or a mean IQ of 110) on the Merrill-Palmer Scale of Mental Tests, and in identification of pictures on the Peabody

TABLE XI

MEAN DEVELOPMENTAL AGE EQUIVALENTS FOR VARIOUS AREAS OF PERFORMANCE OF INFANTS IN DAY CARE COMPARED WITH THOSE OF INFANTS WITH NO DAY CARE EXPERIENCE AT 6 AND 9 MONTHS

	Mean MDI*	Mean PDI**	Mean Developmental Age Equivalent						
			Gross Motor	Fine Motor	Exploration	Competence	Social Relatedness	Perceptuo-Cognitive	Language
6-Month-Olds in Day Care 3 months or more (n=18)	119.9	112.9	6.6	6.4	6.9	6.8	6.3	6.3	6.1
6-Month-Olds with No Day Care Experience (n=7)	120.3	110.0	6.6	6.8	6.8	6.7	6.6	6.4	6.2
9-Month-Olds in Day Care 3 months or more (n=[illegible])	121.6	111.2	9.6	10.6	9.8	9.0	8.5	9.0	8.4
9-Month-Olds with No Day Care Experience	117.3	107.6	9.5	10.0	9.6	8.3	7.9	8.8	8.1

* MDI: Bayley Mental Development Index
** PDI: Bayley Psychomotor Development Index

Table XII

DEVELOPMENTAL TEST SCORES AT TWO YEARS OF AGE

		Bayley Mental Scale: MDI	Approx. Age Equiv. Mos.	Bayley Motor Scale: PDI	Approx. Age Equiv. Mos.	Merrill-Palmer: Mental Age	PPVT: Mental Age	Stanford-Binet: Mental Age
Normal Group	x	112.40	26.0	111.40	26.0	27.50	25.11	28.67
	SD	12.03		9.52		2.20	2.47	3.14
	n=	10		10		8	9	6
Girls	x	117.14	27.0	111.14	26.0	28.00	25.67	28.67
	SD	11.01		9.32		2.55	2.73	3.14
	n=	7		7		5	6	6
Boys	x	101.33	24.0	112.00	26.0	26.67	24.00	--
	SD	5.03		12.12		1.53	1.73	--
	n=	3		3		3	3	--
High Risk Group	x	103.67	24.5	112.78	26.5	25.90	24.38	27.25
	SD	12.20		8.44		1.91	2.07	1.50
	n=	9		9		10	8	4
Girls	x	106.40	25.5	114.20	27.0	27.20	24.75	28.50
	SD	12.62		11.50		1.30	1.89	0.71
	n=	5		5		5	4	2
Boys	x	100.25	24.0	111.00	26.0	24.60	24.00	26.00
	SD	12.50		2.45		1.52	2.45	0.00
	n=	4		4		5	4	2
Total Group	x	108.26	25.5	112.05	26.0	26.61	24.76	28.10
	SD	12.59		8.80		2.15	2.25	2.60
	n=	19		19		18	17	10

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Picture Vocabulary Test they acheived a mean Mental Age of 24.8. While only 10 of the 20 two-year-olds examined with the Stanford-Binet Intelligence Scale passed all of the two-year items to yield a scorable record, the group as a whole passed an average of 5.2 of the six Stanford-Binet items at the Year II level, with no clear pattern of passes or failures. All but one of the 20 received credit at this level for completing the three-hole form board, 18 for identifying parts of the body, and 17 for the delayed response and for using two-word combinations. It should also be noted that the two-year-old group passed an average of 2.2 of the six Stanford-Binet items placed at the Year II-6 level, and that 12 of the 20 children passed between one and three items at the Year III level of the Stanford-Binet.

A sex difference was noted at two years, with the girls as a group invariably tending to score higher than the boys on all measures used. While the differences in overall scores were not found to be statistically significant, a difference was apparent in number of items passed on the Stanford-Binet, with the girls receiving credit for an average of 9.9 items as compared to the boys' average of 6.9 items, which proved to be significant at the .05 level (two-tailed test, U=20).

The overall test findings indicate that the Center's two-year-old graduates as a group appeared to be functioning within the normal range or better on a variety of measures considered to be of fundamental developmental importance.

The longitudinal infant subsample was further divided into two subgroups; those whose birth was normal (n=13) and those who had experienced one or more significant high risk birth conditions (n=11), such as prematurity or low birthweight, in order to examine the possible impact of such conditions upon developmental outcome and pattern. No significant differences were found in the mean Bayley mental and motor developmental indices (MDI & PDI) between normal and high risk groups at any of the ages examined. Table XIII summarizes the mean developmental age equivalents in months for both normal and high risk birth condition subgroups at various ages obtained for different areas using the Bayley Infant Scale Performance Profile. Figure 1 illustrates the developmental patterns characteristic of the two subgroups at the age of two years. It will be noted from the comparative profiles that there is a trend for the high risk group to lag somewhat behind the normal birth group in the areas of both perceptuocognitive and language development at this age. Other areas show average-range development for both infant groups.

An attempt was then made to explore the developmental impact of the possible interaction between high risk birth conditions and environmental factors in the longitudinal subsample. Although the home environment of the Center infants was not systematically investigated, basic information as to family structure, babies' schedules, and parents' handling of their infant at home was annually collected and assessed by questionnaire. However, because of the demonstrated importance of home environment as a determining

TABLE XIII

BAYLEY INFANT SCALE PERFORMANCE PROFILES OF LONGITUDINAL NORMAL (N) AND HIGH RISK (HR) BIRTH SUBSAMPLES EXPRESSED IN MEAN DEVELOPMENTAL AGE EQUIVALENTS (IN MONTHS)

		Sensory	Gross Motor	Fine Motor	Exploration	Competence	Social Relatedness	Imitation	Perceptuo-Cognitive	Language
6 mo.	N (n=7)	5.9	6.6	6.3	7.0	6.8	6.2	-	5.8	5.4
	HR (n=6)	6.0	6.5	6.8	7.0	6.9	6.7	-	7.0	6.0
12 mo.	N (n=12)	-	14.0	12.7	12.0	13.1	11.5	13.8	12.5	11.1
	HR (n=9)	-	14.4	13.2	12.7	13.2	11.0	13.5	13.6	11.7
18 mo.	N (n=13)	-	21.3	20.0	-	20.6	-	20.4	21.2	18.8
	HR (n=8)	-	19.5	18.8	-	19.1	-	19.1	19.2	17.1
24 mo.	N (n=10)	-	25.3	25.7	-	26.3	-	24.6	27.1	24.6
	HR (n=9)	-	26.2	25.5	-	25.9	-	25.4	24.9	23.2

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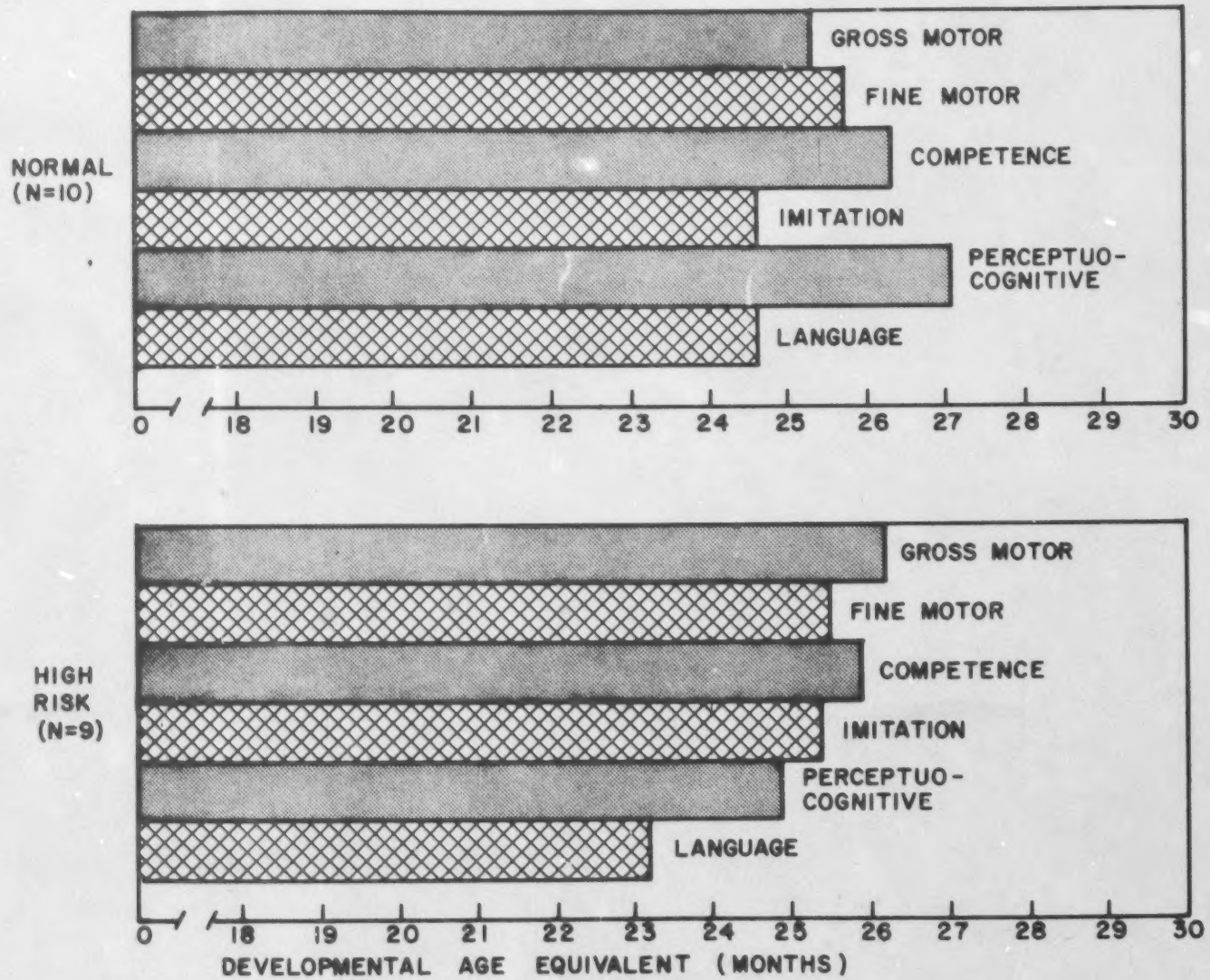
Figure I. BAYLEY INFANT SCALE GROUP PERFORMANCE PROFILE OF NORMAL AND HIGH RISK INFANTS AT TWO YEARS OF AGE.



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factor in the effectiveness of day care intervention programs, an attempt was made to assess the degree of environmental risk present in the child's home situation. Each child was assigned an overall rating of environmental risk derived from ratings received in the following categories·

1. basic physical needs including nutrition and health care
2. quality of mother/infant relationship
3. quality and stability of overall family life
4. level of developmental stimulation provided within the family setting

The information which provided the basis for these evaluations included parent report, questionnaire information, social work interview, psychological test data (including behavioral observation and analysis of mother/infant interaction) and evidence for the occurrence of traumatic critical incidents such as physical abuse or for a significant degree of personality pathology among involved family members.

The ratings assigned to the 24 babies in the longitudinal study ranged (on a scale of 10) from 2, indicating a high degree of environmental risk, to 10, which indicated no perceived presence of risk in the home environment. The average risk rating was 6.3 for the group, with the hign risk birth male babies showing the greatest degree of environmental risk ($x=4.6$). These ratings were then compared to the Bayley developmental scores of the same babies at 6, 12, 18, and 24 months, using Spearman's rank correlation (Table XIV). A correlation coefficient (r_s) of 0.77 was shown between the Environmental Risk Rating (ERR) and the Bayley Mental Development Index (MDI) at 18 months ($p<.01$, one-tailed test), and similarly at 24 months the ERR/MDI correlation coefficient was 0.76 ($p<.05$, one-tailed test). (Figure 2). This relationship was not found to be present at 12 months, and no correlation apparently existed between the ERR and the Bayley Psychomotor Development Index(PDI) at any of the ages examined. Interestingly, a relatively high negative correlation was found at six months between the ERR and MDI. This could be attributable to the fact that the environmental risk ratings were based principally upon the family situation as it was known to be at a later stage in the infant's life. An alternative interpretation could be that the developmental test at six months measures different aspects of infant capability than it does at later ages.

The results are consonant with clinical observations which suggest that the development of infants born at risk for central nervous system dysfunction is especially dependent upon environmental factors, which may serve to prevent or to foster developmental disabilities.

TABLE XIV

CORRELATION COEFFICIENTS (SPEARMAN r_s) BETWEEN ENVIRONMENTAL RISK RATINGS AND BAYLEY DEVELOPMENTAL INDICES FOR NORMAL AND HIGH RISK BIRTH SUBGROUPS AT THE AGES OF 6, 12, 18 AND 24 MONTHS

ENVIRONMENTAL RISK RATING/MENTAL DEVELOPMENT INDEX

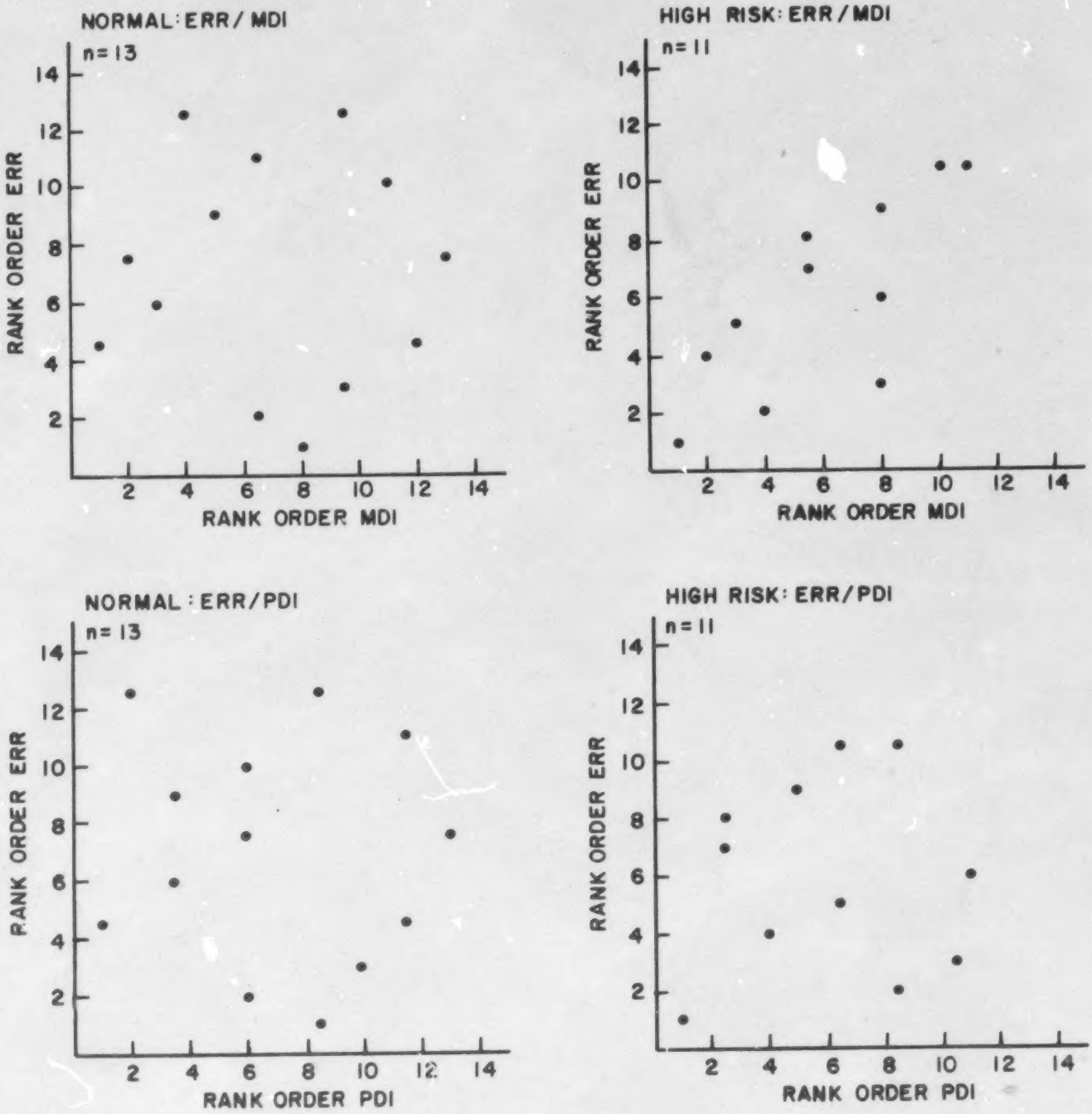
		6 mo.	12 mo.	18 mo.	24 mo.
Normal	n =	8	12	13	10
	r_s =	-0.36	-0.05	-0.01	+0.27
High Risk	n =	9	9	11	9
	r_s =	-0.65*	-0.06	+0.77**	+0.76***

ENVIRONMENTAL RISK RATING/PSYCHOMOTOR DEVELOPMENT INDEX

		6 mo.	12 mo.	18 mo.	24 mo.
Normal	n =	8	12	13	10
	r_s =	+0.16	-0.33	-0.08	+0.40
High Risk	n =	9	9	11	9
	r_s =	-0.30	+0.15	+0.06	+0.05

* $p < .05$ (one-tailed test)
** $p < .01$ (one-tailed test)
*** $p < .05$ (one-tailed test)

Figure 2: RANK CORRELATION OF ENVIRONMENTAL RISK RATING (ERR) WITH BAYLEY MENTAL DEVELOPMENT INDEX (MDI) AND BAYLEY PSYCHOMOTOR DEVELOPMENT INDEX (PDI) FOR NORMAL AND HIGH RISK BIRTH SUBGROUPS AT 18 MONTHS OF AGE.



Follow-up Tests

An effort was made to re-establish contact with the Center graduates and continue to monitor the children's development at least at yearly intervals; however, the amount of follow-up test data which was possible to obtain was limited. Nine of the babies had graduated within the final six months of the program, too late to permit follow-up. Of the other 15, two mothers were unable to be located, two refused to permit the follow-up testing, and three were agreeable but unwilling to take the trouble. Eight babies were successfully tested; seven at 2½ years of age, 6 at 3 years, and 3 at 3½ years. The results are presented in Table XV. It was found that IQ as measured by the Stanford-Binet generally remained within the average range. The three children tested at age 3½ earned a mean IQ of 111* on the Stanford-Binet (based on 1972 Revised norms) and 105 on the PPVT.

Interpretation of these results must necessarily be limited, not only by the small amount of data but also by the probability that children who were made available for follow-up testing belonged in the first place to the more involved and cooperative mothers, which would be a selection factor. Of the eight babies tested, five had ratings which indicated a very low degree of environmental risk (8-10). The other two had extremely high risk ratings (2.0 and 2.5).

* Equivalent to IQ=122 by Pinneau (1960) norms.

TABLE XV

DEVELOPMENTAL PROGRESS OF FDC GRADUATES:

SCORES OF 8 CHILDREN ON FOLLOW-UP TESTS*

Subject	Scores at 2 yr.	Scores at 2½ yr.	Scores at 3 yr.	Scores at 3½ yr.	Environmental Risk Rating
A Female	MDI=132; PDI=122 M-P: IQ=121 PPVT: MA=2-4 S-B: IQ=129	M-P IQ=110 S-B IQ=119	PPVT IQ=89 S-B IQ=113		8
B Female	MDI=102; PDI=105 PPVT MA=1-10 S-B IQ=96	M-P IQ=107 PPVT IQ=89 S-B IQ=101		PPVT IQ=105 S-B IQ=111	10
C Female	MDI=132, PDI=111 M-P IQ=133 PPVT MA=2-2 S-B IQ=112(est)	PPVT IQ=92 S-B IQ=104	PPVT IQ=98 S-B IQ=108	PPVT IQ=108 S-B IQ=116	8
D Female	MDI=88, PDI=126 M-P IQ=112 PPVT MA=2-1		PPVT IQ=78 S-B IQ=78(est)		2
E Female	MDI=100, PDI=120 M-P IQ=112 PPVT MA=1-10 S-B IQ=100	PPVT IQ=96 S-B IQ=95			9
F Male	MDI=106, PDI=126 M-P IQ=117 PPVT MA=2-1		PPVT IQ=79 S-B IQ=103	PPVT IQ=102 S-B IQ=107	8.5
G Male	MDI=108, PDI=134 M-P IQ=100 S-B IQ=96		S-B IQ=92		2.5
H. Male	**MDI=116, PDI=124 M-P IQ=104 PPVT MA=2-2 S-B IQ=96		PPVT IQ=79 S-B IQ=91		5

MDI: Bayley Mental Development Index
PDI: Bayley Psychomotor Development Index
M-P: Merrill-Palmer Scale of Mental Tests
PPVT: Peabody Picture Vocabulary Test
S-B: Stanford-Binet Intelligence Test (Form L-M)

* Stanford-Binet IQ scores reported are based on 1972 Revised norms and are an average of 10 points lower than when Pinneau (1960) norms are used.

** Scores at 21 months.

TEACHER PERSONALITY AND PROFESSIONAL ROLE EFFECTIVENESS

What are the characteristics of an effective caregiver and educator of infants? Who is able to function well within the day care center context, in relation with other staff members and parents as well as with children? Who is attracted to this newly emerging profession and what are the opportunities--and possible disappointments--that it offers? Are there important sex differences? These are some of the questions which increasingly concerned us as their relevance became apparent and which have been explored in this research from a number of different perspectives.

Recent reports suggest that the characteristics of the teacher or child care worker may be the single most important variable upon which the success of the program hinges (e.g., Sigel, 1969). With this in mind, we have first considered the bases upon which our teachers were selected: the personal qualities, educational background and work experience. Second, we have examined the teachers' own self-perception by asking them to describe their own personalities, needs and strivings by means of self-description tests. Finally, we have utilized evaluations of the individual teachers' professional role effectiveness and suitability in an effort to determine any relationships revealed by this information and their possible impact upon the children's growth and development.

Teacher Group

The group of teachers employed by the FDC in its four years of operation consists of 24 persons: 17 women and 7 men who range in age from 18 to 46 years. Excluding four of the number who were substitutes, their average length of employment was 15 months. They represent a variety of backgrounds in terms of educational and work experience. All are high school graduates; six are college graduates and one has had graduate school training in education and earned a teaching credential. The working experience of the group includes other day care situations, babysitting, theater, elementary school teaching, and clerical work. In general, it is evident that this group was not drawn from the ordinary white collar business or professional world, and perhaps represents a special kind of individual seeking a new, unique and satisfying occupation.

While the FDC teachers as a group appear to accept and participate in the research nature of the project at an intellectual level, they also view themselves as a professional group with a certain status and had some difficulty in accepting the position of being, themselves, objects of observation. Fears were expressed that such tests might be added to their personnel folders and serve as a basis for decisions concerning promotions or even being fired. They were assured that such test data would be treated completely separately from personnel decisions and would in fact, be seen and analyzed by only a few members of the research team who had no connection with such matters. Nevertheless, a certain amount of initial anxiety and reluctance concerning this testing was difficult to dispel. On the other hand, as the teachers themselves became more

involved in the gathering and interpretation of observations and test data concerned with their infants, such as a study of separation anxiety for which they had a major responsibility, their attitude became somewhat modified.

Certain difficulties are inherent in the complex dynamics of a research and demonstration project where the personnel must study themselves as well as the impact of their program. We have found that many of these problems can be resolved through continuing in-service experiences which encourage direct communication and build up a sense of mutual participation and a greater trust and understanding of the nature of research enterprise.

Test Results

The self-perception tests used with the teachers were the Edwards Personal Preference Schedule (EPPS), the Adjective Check List (ACL), for both actual and ideal self, and Gordon's How I See Myself scale.

While the Adjective Check List and the Edwards Personal Preference Schedule are both self-descriptive scales, based on the same system of needs, they differ in certain important respects. In contrast to the ACL, direct choice of self-descriptive adjectives, the EPPS requires the assertion of a preference for one activity as compared with another which may be less obviously associated with a particular trait. In view of this, it may be significant that mean percentile scores on the EPPS for the group show a wider range of variation with respect to the various needs than is found with the ACL results, which tend to cluster more closely around the 50th percentile (Table XVI). Nevertheless, the EPPS has been designed to control for social desirability for the paired items.

When the results of the EPPS were examined separately for male and female teacher groups, several interesting differences emerged. Female teachers showed significantly high dominance ($p < .05$) and exhibition ($p < .02$) needs as compared to males, and a relatively low need for affiliation ($p < .02$); male percentile scores on these variables were within the average range. The male group exhibited a trend toward a significantly higher achievement need (perhaps an important consideration from a career point of view) than that of their female counterparts, as well as the highest percentile score on any variable (80.7) in the area of intraception, or the need for empathetic understanding and insight into the motivations of others. The sex groups were similar in relatively high needs for autonomy and for change, and correspondingly low need for deference, abasement, order and endurance.

On the ACL, the female teachers described themselves as significantly more dominant ($p < .05$) and exhibitionistic ($p < .05$) than male teachers. The male self-description indicated a higher need for abasement ($p < .05$). As previously noted, however, the ACL scores as a whole showed little deviance from the mid point of the percentile range.

TABLE XVI

MEAN PERCENTILES AND RANK ORDER OF NEEDS
FOR MALE & FEMALE TEACHERS OBTAINED ON
THE EDWARDS PERSONAL PREFERENCE SCHEDULE
AND ADJECTIVE CHECKLIST

MANIFEST NEED:	(n=16) FEMALE TEACHERS						(n=7) MALE TEACHERS					
	EPPS			ACL			EPPS			ACL		
	Rank	Mean %ile	SD	Rank	Mean %ile	SD	Rank	Mean %ile	SD	Rank	Mean %ile	SD
Achievement	9	43.6	22.8	10	49.5	6.8	6	63.0	27.1	10	47.4	11.0
Deference	13	29.4	25.3	13	47.3	7.0	14	24.1	17.8	8.5	48.3	9.2
Order	14	27.1	23.4	12	48.6	6.0	15	20.0	17.4	11	46.4	10.6
Exhibition	2	72.8	22.0	1	53.6	9.0	9	45.4	21.6	14	45.0	8.0
Autonomy	3	71.9	15.8	2	53.1	6.7	2	72.0	24.3	6	51.0	9.7
Affiliation	12	29.6	23.3	9	49.9	8.7	7	59.7	29.9	8.5	48.3	5.6
Intraception	8	58.4	26.9	6	51.8	9.6	1	80.7	20.5	2	55.7	4.3
Succorance	6	60.2	33.8	14	45.6	9.0	4	68.0	23.9	13	45.3	10.6
Dominance	5	63.8	28.2	4	52.2	5.9	10	40.1	13.6	15	43.4	11.2
Abasement	15	20.5	11.8	15	44.8	5.8	12	31.9	23.0	4	52.1	8.3
Nurturance	10	40.1	31.6	7.5	51.0	7.0	11	36.9	16.1	3	52.7	6.9
Change	4	66.2	30.2	3	53.1	9.1	3	70.9	22.1	1	58.3	15.7
Endurance	11	31.1	27.7	11	48.9	6.1	13	30.4	27.5	7	48.9	15.3
Heterosexuality	1	79.2	15.8	5	51.8	10.2	5	66.0	24.0	5	51.4	6.1
Aggression	7	58.6	27.7	7.5	51.0	7.5	8	47.7	14.6	12	45.6	7.9

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The teachers evaluated their self-perception on the How I See Myself scale, using a scale of 1 to 5 from negative to positive, on items grouped into seven areas: physical appearance, physical adequacy, teacher/school attitude, interpersonal adequacy, academic adequacy, autonomy and emotions. The self-images appeared generally positive (scores above 3.00), with only a few scattered scores in the 2-3 range and all group means between 3.00 and 4.30. The only notable sex difference appeared in the "academic" area, where the men showed a higher image of their academic ability than did the women.

The composite personality picture which emerges from these results is that of a female teacher who is self-reliant, dominant, perhaps egocentric, with a desire for new experiences and a need to be the center of attention. The composite male teacher, on the other hand, appears as a quiet, more reflective personality, less assertive, more dependent upon friendship and support from others and more in need of a sense of achievement from his efforts.

In an earlier analysis, teachers were also asked to repeat the Adjective Check List, this time selecting the words which would describe their ideal selves. The five words which received the highest number of choices were evaluated in terms of which of the various manifest needs they most indicated. The words most often chosen by the female staff were : alert, artistic, courageous, determined and patient. These ideal choices are most indicative of dominance, achievement and endurance needs. The congruence between these ideal needs and the needs as expressed in their self profile suggest a basic harmony between self and ideal self.

The words most often chosen by the male staff were: inventive, calm, confident, outspoken, and spontaneous. They are most often associated with need dominance and need autonomy. This is in contrast to the relatively low position that dominance held on their self profiles, and suggests an incongruence between self and ideal self.

The sex differences apparent in these findings s[illegible]st possible differential influences upon the teacher selection proces[illegible] The criteria used in hiring may have differed for female and for male applicants, at least along the variables of self-confidence, dominance and exhibition; or male and female applicants for this type of position may tend to differ with respect to these variables. It is also likely that input from a largely female teaching staff was a deciding factor in the selection of new staff members and was weighted in favor of certain personality types.

The tendency which showed up across the teacher group to manifest a desire for autonomy and for change, along with low endurance and little need for order, may indicate that this profession has appeal for persons who would be less suited to other more structured and restrictive work situations.

Teacher Ratings

Teacher performance was rated independently on a subjective basis by the pro[redacted] director and by the nursery director. Ratings were made on a 1-5 scale for 30 teacher characteristics, grouped into 11 categories (See Appendix) for each of 21 teachers. (Two additional teachers were rated by only one observer; these ratings were excluded from the comparison.) When the ratings were compared to determine reliability, perfect inter-rater agreement was 45% overall. Per cent of agreement within one point was 90%-100% for all categories except category VII (Dependability), which was 76%. Best rate of perfect agreement (76%) appeared for category III (Response to Parents); poorest perfect agreement, (19%) for category V (Response to Supervision, Policies & Administration).

Teacher performance ratings were also divided into "acceptable" (rating of 3 or higher) and "non-acceptable" (rating of 1 or 2). In this context, inter-rater agreement ranged from a high of 95% (categories IX and XI) to a low of 76% (categories V and VIII).

Ratings for the 11 categories were totalled for each subject. Of a possible perfect total score of 55 points, Rater #1's scores ranged from 19.00 to 52.67 (mean=37.71); Rater #2's scores ranged from 16.25 to 50.30 (mean=34.35)

The total score for each subject was divided by 55 to yield a percent-score. Range of percent-scores was 29.5 to 95.8 (mean=66.0). Percent-scores were rank-ordered for each rater and yielded a rank-order correlation coefficient of 0.90.

Raters additionally indicated whether or not they would rehire each teacher. There was perfect agreement throughout the ratings on this point. This decision, however, was not entirely consistent with point scores. The 12 teachers who would be rehired had overall percent-scores ranging from 55.1 to 95.8 (mean=76.0), while the 9 teachers who would not be rehired by either rater had scores ranging from 29.5 to 74.7 (mean=51.4). The overlap area of these two ranges (55.1-74.7) included 42% of the "rehire" and 50% of the "no rehire" teachers. The indication would be that there were other important factors involved in the rating system, such as heavier weighting of some items than others, which influence a decision as to whether a teacher is suitable to be employed again in this work.

It was found that most of the "no rehire" group had excessive absenteeism and many were chronically tardy. All except one had created tensions in the nursery because of behavior outbursts and confrontations with other staff and parents, or by depressive, withdrawn and uncommunicative behavior. Seven of the nine were constant complainers who seldom if ever dealt directly with the source of the complaints. Several never seemed to accept the concept of "professional conduct" and spent a lot of time gossiping and making negative comments about the other staff members to the parents.

Although some of the "no rehire" group were good-to-excellent workers when they began their employment, they lost interest and "burned out" over time. These usually had attended college and sometimes had college degrees. They felt that they should be advancing and progressing and lost motivation when it became obvious that there was little opportunity for advancement with resultant salary increases. They felt the need for change and for more intellectual stimulation than they got on a daily basis: in-service training at periodic intervals was not enough to meet their needs. Many especially burned out because of the parents' lack of cooperation and criticism of them.

The difference perceived with the "rehire" group is that they proved to be good, consistent, steady workers over a long period of time. Most of them had better than average work attendance. They were emotionally stable people with endurance and tolerance for the parents, even though they felt critical of them at times. They had enjoyment for the work that they were doing and saw their job as their chosen profession rather than as "just a job" or a stepping stone to something better. All were striving for self improvement and staff development, but were generally willing to work for change within the policies of the agency. They tended to have realistic attitudes towards the needs of the administration and understood the basic goals of the Center. They were pleasant individuals who showed flexibility in their roles and who helped other staff members voluntarily. None were the explosive or depressive types who tend to have a negative effect on the atmosphere of the Center.

EVALUATION OF THE ACCOMPLISHMENTS

We have successfully provided an optimal facility and environment for the operation of a model infant care program. We feel very positive about our program for the children and feel that this day care model is advantageous for the infants of any age parents. Furthermore, we recommend our infant education program for children in any care situation. We have had a number of requests for infant program information from the parents of children being reared at home, as well as from persons who are operating family day care homes.

For adolescent parents, the method of teaching is as important as the content presented; we believe that we have successfully provided a model which has an optimal chance for success with this group.

An infant center's real effectiveness depends heavily on the skills, personalities, and cooperation of its caregivers; our model of in-service training and staff development with an emphasis on communication skills and self knowledge is an important accomplishment which we wish to emphasize.

We are satisfied that we have produced five publications containing information that has been requested by many people. We think that they will be widely used. Another important accomplishment has been the demonstration of the program to a large number of visitors, many of whom are already modeling many of our ideas.

Last of all, we have accomplished continuity of a model program through a contract with the San Francisco Unified School District for service to 20 families. The school district has asked for the complete services developed under the demonstration grant including individualized programming for the children, a parent program, and educational, career and job counseling for the school age parents.

A three year demonstration grant from the Bureau of Education for the Handicapped, Office of Education, to integrate an individualized program for young high risk/handicapped children into the existing program, has added to the scope of the total Center. A Center based home visit program to the homes of additional high risk and handicapped infants and a program for the parents of these children add another dimension to the program.

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Films:

The two films, Person to Person in Infancy (#9299) and Psychological Hazards in Infancy (#9298), were furnished by Modern Talking Picture Service, Inc., 16 Spear Street, San Francisco, Calif. 94105

APPENDIX

CORRECTIONS

Problems Relating to Site Finding and Recommendations for Mitigating Code-Incurred Delays and Costs was written in March, 1973 for inclusion in that year's annual progress report.

Visitors to Family Developmental Center and Information Disseminated: June 1973-1975, page 1, paragraph 1, line 6 should read "small groups".

Page 13, Catherine Maddox should have been placed on page 16 under areas outside of San Francisco and California.

Mother-Child Interaction, Female Baby D, Eye-Hand Coordination, paragraph 2, line 3, should read "the task without interfering".

Mother-Child Interaction, Female Baby E, Gross Motor, paragraph 1, line 3, should read "stood on one foot herself".

Problems Relating to Site Finding and Recommendations for Mitigating Code-Incurred Delays and Costs*

Our purpose here is to outline the difficulties in obtaining a legally adequate building physically adaptable to the Family Developmental Center's program needs as well as to state and city building codes and licensing standards in a city with the country's highest construction costs. It is a reliable assumption that our problems are and will continue to be characteristic of those normally encountered in finding and renovating a suitable physical facility for child care in any large urban core area. The only likely exception to that rule are the special requirements of California's Field Act, related to seismic safety.

Several generally applicable constraints sharply narrowed our range of location possiblilities at the outset. They were:

1. The necessity to rent rather than purchase: Without outside private assistance, the Family Developmental Center could not consider acquiring its own facility. A five-year funding term makes purchase economically unfeasible, and political prudence precludes the assumption of continued financial support beyond five years. The net effect is that many buildings, (this factor is especially applicable to residential uses) are ruled out because landlords are reluctant to permit the kinds of structural alterations required both by the functional necessities of the project and by the health and safety codes. Permanent partitioning and the installation of sprinklers, for instance, are objectionable unless the project is in a position, and we were not, to make costly commitments required to return a building to its original condition upon lease expiration.

2. State licensing requirements for child care space: State law (State Administrative Code, Title 22, Section 31204) requires a minimum of thirty-five square feet per child. This means, for a project like ours, with an anticipated enrollment of 50 babies, that a building must have 1,750 usable square feet on the ground floor. State law prohibits child care operations above the first floor except in a Type I building (four-hour fire resistant exterior walls, brick or masonry and concrete floor; or steel frame, fireproofed.) It is possible to obtain a waiver of the first floor requirement by appeal to the city's Board of Permit Appeals and a mitigation of the square footage standard from the State Department of Social Welfare. We made an early decision that it was both dangerous and inappropriate for either Family Service Agency or Family Developmental Center to seek exceptions to legal standards protective of the health and safety of the children for whom they are responsible.

* Written by Patrick Devaney and James Weber, Architect, Board members of the Family Service Agency of San Francisco.

3. City zoning standards for child care uses: Child care is a nonconforming use in all residential districts. In order to obtain approval of a conditional use, it is required by the Department of City Planning that the prospective use be posted in the neighborhood, that all property owners within 300 feet be notified in writing, that a public hearing be held and that approval of the Planning Commission be voted. If that process, which may require as long as six months, does not eventually deny the nonconforming use, it is usually guaranteed to raise sufficient objections from neighboring householders to prejudice the Center's community relations indefinitely. An early decision has to be made whether to risk Center planning time and capital in such an unpromising venture.

4. Transportation: Many of the Family Developmental Center parents have to rely upon public transportation to bring their babies to the Center. That consideration rules out locations where municipal railway service is either infrequent or available only at a distance from the Center which makes walking to and from a stopping point so onerous as to eliminate all families without private automobiles.

Any one of the foregoing constraints is sufficient, by itself, to eliminate a building as a legal and/or economic possibility. Taken together, they constitute a formidable barrier to qualifying any building for initial feasibility and worth the additional investment of staff or consultants' time in the detailed investigations calculating whether that building can be adapted to the project's needs, as well as to state and city building codes and licensing requirements, and all within the budget for renovation construction.

A general conclusion of our search for a facility is that hospital and clinic buildings, school buildings, automotive repair and garage buildings, light industrial buildings, and warehouses have the best potential for renovation into a code and ordinance-complying day care facility. However, the procedural difficulties (bureaucratic red tape, a gamut of autonomous code enforcement bodies with overlapping jurisdictions and resulting extensive time, effort, and man-hour cost), and the construction cost to satisfy all applicable ordinances are great even with the best available building situation.

The structures which we most seriously considered are typical of the choices available in an urban housing and building stock:

978 Guerrero Street: a wood frame, 4,500 square foot, 2½ story plus basement, former residence built in 1915, converted to a rest home in the 1950's.

Army & Valencia Streets: an automotive garage built in the 1920's including a two-story wood frame reception, office and residential unit portion and a large masonry wall with high steel truss ceiling shop area.

15th & Folsom Streets: Center for Educational Development owned by the Far West Laboratory for Educational Research and Development, a 3,300 square foot, high ceiling ground floor area in a six-story former warehouse which after two years of extensive renovation complies with state and city building codes.

We chose the Far West Laboratory building location because it presented the only chance of getting necessary state and city code approval within a reasonable time frame. The six-story concrete and masonry structure has already undergone two years and three and a half million dollars worth of code-conforming renovation. Building officials were closely familiar with the structure; architectural and engineering plans, specifications and calculations were a matter of record, and building contractors and subcontractors were still working on construction in the building. The facility had been totally rebuilt. Approved systems for plumbing, electricity, heating, air-conditioning and fire sprinklers already existed in and adjacent to the day care center space. The building was approved structurally, including tough earthquake requirements. The space includes improved adjacent outdoor area which fulfills state day care licensing requirements for outdoor play space.

The public code agencies and building officials with jurisdiction over the Family Developmental Center facility presently under construction are:

State of California O.A.C. (Title 19 and 24)
State Fire Marshall (Title 19)
State Department of Social Welfare (Title 22)
San Francisco Building Department
1. Building Inspector
2. Fire Inspector
San Francisco Department of Public Health

If either of the other buildings considered had been considered feasible for renovation, the zoning changes previously described would have added to our cast of interested officials the Department of City Planning and perhaps the Board of Permit Appeals. Total time for design, construction document approvals, bidding and construction is normally approximately six months. A zoning change procedure would have added another six months to our time frame.

Specific code-induced costs required for the Family Developmental Center renovation to date include:

A. By the City Fire Inspector after O.A.C. and State Fire Marshall approval:

1. Interior rated doors and windows with rated frames.
2. One added fire alarm pull station.
3. Panic hardware at exterior gates . . . . .About $1,350

B. By San Francisco Department of Public Health:

1. Floor drains at kitchen and bathroom $500
2. Increased formica black splash to underside of cabinets 115
3. The architect convinced the Public Health Inspector give a liberal interpretation on the kitchen code requirement. The Inspector wanted to classify the kitchen in the same category as a food service establishment which requires stainless steel counters and wainscots and quarry tile floors. Potential cost 2,000

Based upon the experience of the last six months, it is possible to make some recommendations which can mitigate code-incurred delays and costs and can remove or adjust some arbitrary and irrational constraints to child care center construction. These are set forth below under the headings, "Office of Child Development" and "Codes," depending upon whether those changes can be most reasonably made at the federal or local level.

1. Office of Child Development

One of the major deterrents to locating and remodeling a day care center is the scarcity and the expense of expert consultants to assist a center staff and/or volunteer board through a maze of legalistic code and licensing requirements. Diversion of staff from work with children to coping with architectural and bureaucratic tasks is neither productive nor cost effective. There should be available, preferably at the regional level of the Office of Child Development, a "child care center consultant" who can advise and assist staff and volunteers in site location and construction. Only minimal training should be required to familiarize one regional staff member with state and city licensing and code requirements. He could be available on an "as needed" basis to day care centers in the region in addition to other regular responsibilities.

The $25,000 limitation upon day care center renovation construction should be replaced with a sliding scale which takes account of varying construction costs, nationwide, with special reference to urban core areas where high building costs and a disproportionately dilapidated housing stock generally prevail. Family Developmental Center and Family Service Agency have excellent reason to know and be grateful for the fact that it is possible to obtain a waiver of the subject cost limitation, but it would be both rational and efficient to make the regulations responsive to widely differing labor and material costs in different parts of the country.

An inexpensive and practical short-cut to qualifying professional staff and/or volunteers in site finding and construction would be the sponsorship by Office of Child Development of a day care center building manual. It would include a "shopping list" based upon typical urban building uses and types, with which a layman could recognize and eliminate from consideration uneconomical or illegal structures. It should spell out prevailing renovation construction costs and describe code-incurred improvements characteristic in core area housing and commercial stock.

2. Codes

In numerous instances state and city codes are conflicting, overlapping and excessively restrictive. Based upon our experience, it is wasteful to divert time and energy from project developments in seeking to change irrational and duplicatory statutes and standards. Codes are guarded like "holy writ" and highly change-resistant. What is helpful is to "boil down" the existing bureaucracy by seeking a change in code application procedure rather than in the statutory standards. As of March 1, 1973, a new California state law became effective which provides that schools, hospitals and nursing homes come under the exclusive code enforcement jurisdiction of the state Office of Architecture and Engineering. If day care centers were added, by amendment, to that law, it would reduce the code officials with jurisdiction in our case (Family Developmental Center) from six to two and eliminate two of the three different fire inspectors involved in this one project. Savings to project completion schedules and time-incurred costs could be impressive.

It is our intention to encourage legislation in the current session of the California State Legislature to accomplish this modification.

FAMILY DEVELOPMENTAL CENTER

1. Poor (often not meeting Center standards)
2. Fair (sometimes does not meet Center standards)
3. Good (meets Center standards consistently)
4. Very Good (more than meets Center standards)
5. Excellent (outstanding)

Teacher_____

Date_____

Rater_____

TEACHER RATINGS

		1	2	3	4	5
I.	**RESPONSE TO CHILDREN'S SAFETY AND PHYSICAL CARE**					
1.	(3.) Awareness of children's activities					
2.	(9.) Physical care of the children					
II.	**RESPONSE TO CHILDREN'S EMOTIONAL AND DEVELOPMENTAL NEEDS**					
1.	(1.) Sensitivity to children's developmental and emotional needs					
2.	(11.) Dependability in carrying out stimulation programs					
	(Rate items I & II seperately for years 1 & 2, if indicated)					
III.	**RESPONSE TO PARENTS**					
1.	(2.) Maturity and ability to be a good role model to parents					
2.	(7.) Ability to maintain a pleasant relationship with parents					
3.	*(19.) Interprets stimulation programs to parents					
4.	*(20.) Explains nursery routines to parents					
IV.	**RESPONSE TO OTHER TEACHERS**					
1.	(18.) Ability to get along well with other teachers					
2.	*(29.) Acceptance of behavior on job by other teachers					
V.	**RESPONSE TO SUPERVISION, POLICIES & ADMINISTRATION**					
1.	(14.) Ability to take & accept direction from supervisor					
2.	*(25.) Follows Center medical procedures as outlined in Handbook					
3.	* (26.) Seeks information from appropriate supervising person when needed					
4.	*(28.) Willingness to follow Personnel Policies and administrative goals					
VI.	**SELF-DIRECTION**					
1.	(5.) Dependability in keeping records					
2.	(8.) Use of time productively					
3.	(10.) Ability to organize own work					
4.	(16.) Housekeeping					
VII.	**DEPENDABILITY**					
1.	(12.) Attendance					
2.	(13.) Promptness					
3.	(4.) Willingness to assume responsibilities of job description					
VIII.	**FLEXIBILITY**					
1.	(15.) Flexibility in changing schedule					
2.	(20.) Willingness to help others when own work load permits					

1. Poor (often not meeting Center standards)
2. Fair (sometimes does not meet Center standards)
3. Good (meets Center standards consistently)
4. Very Good (more than meets Center standards)
5. Excellent (outstanding)

Teacher _____

Date _____

Rater _____

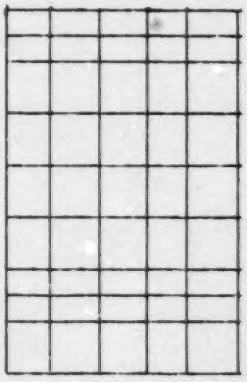
TEACHER RATINGS

	1	2	3	4	5

IX. ABILITY TO UNDERSTAND AND EXPLAIN EDUCATIONAL ASPECTS OF THE JOB TO OTHERS
- 1. (6.) Ability to interpret program to visitors
- 2. (17.) Participation in in-service training

X. CREATIVITY
- 1. *(21.) Ability to be innovative; inject new ideas into program
- 2. *(27.) Uses materials at hand and situations which occur to carry out suggested activities

XI. EMOTIONAL TONE
- 1. *(22.) Emotions are in control and on an even keel
- 2. *(23.) Enthusiasm for job, children and activities
- 3. *(24.) Effect of personality on the atmosphere of the Center

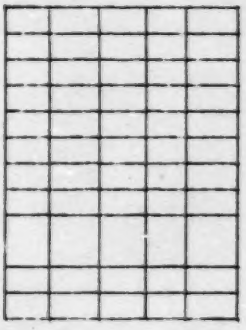


* New Items

SUMMARY

	1	2	3	4	5

I. RESPONSE TO CHILDREN'S SAFETY AND PHYSICAL CARE
II. RESPONSE TO CHILDREN'S EMOTIONAL AND DEVELOPMENTAL NEEDS
III. RESPONSE TO PARENTS
IV. RESPONSE TO OTHER TEACHERS
V. RESPONSE TO SUPERVISION, POLICIES & ADMINISTRATION
VI. SELF-DIRECTION
VII. DEPENDABILITY
VIII. FLEXIBILITY
IX. ABILITY TO UNDERSTAND AND EXPLAIN EDUCATIONAL ASPECTS OF THE JOB TO OTHERS
X. CREATIVITY
XI. EMOTIONAL TONE



Would hire again _____

Would not hire again _____

The agenda for the May 1973 training program is reproduced below:

TUESDAY, MAY 1 A.M. —— Orientation and Introduction of Staff

—— Social Worker's Role in Center
—— Confidentiality
—— Admission Policies and Procedure

—— Rundown of what Pre-service Training is about
—— Assignment of Trainees to Head Teachers and to Specific Babies
—— Discussion of Individual Babies

P.M. —— Role of the Research Associate
—— Explanation of the Bayley Scales of Mental and Motor Development and other Tests and Scales used in the Research
—— Teachers' and Parents' Role in the Research
—— Stimulation Programs and Child Activity Record

—— Role of Project Director
—— Licensing Requirements for Center
—— The Grant Proposal and the Overall Research Design

—— The Relation of the FSA and the Executive Director
—— Personnel Policies

—— Role of Nursery Coordinator/Health Director
—— Health Component; Medical Procedures in Center
—— Teachers' Responsibilities

WEDNESDAY, MAY 2 A.M. —— Clinical Practice in FDC Nursery;Meeting Babies, Parents, and Other Teachers, etc.

P.M. —— The Teen Years
—— Family Planning
—— Reading Period; Material Distributed
—— Nursery Practicum

THURSDAY, MAY 3 A.M. —— Group A - Initial Placements in Newborn Nursery at St. Luke's Hospital
—— Group B - Discussion of Individual Babies and their Stimulation Programs
—— Group C - Practicum in FDC Nursery

P.M. —— Teenage Parenthood (Film)
—— Practicum in FDC Nursery

FRIDAY, MAY 4 A.M. —— Pre-natal and Neo-natal Development

P.M. —— Development from Birth to Six Months and Stimulation Techniques
—— Film "Learning to Learn in Infancy"

MONDAY, MAY 7 A.M. — Group A - Nursery Practicum
— Group B - Newborn Nursery Placement
— Group C - Discussion of Individual Babies and their Stimulation Programs

P.M. — Development from Six Months to One Year and Stimulation Techniques

TUESDAY, MAY 8 A.M. — Nursery Practicum

P.M. — Development from 1 year to 2 years and Stimulation Techniques

WEDNESDAY, MAY 9 A.M. — Film: "Discipline and Self Control"

P.M. — Problems Within Normal Development; e.g. Toilet Training, Discipline, etc.

THURSDAY, MAY 10 A.M. — Group A - Discussion of Individual Babies and their Stimulation Programs
— Group B - Practicum in FDC Nursery
— Group C - Placement in Newborn Nursery

P.M. — First Aid and Nursery Procedure

FRIDAY, MAY 11 A.M. — Nursery Practicum

P.M. — Nutrition
— Film: "Jenny is a Good Thing"

MONDAY, MAY 14 A.M. — Nursery Practicum

P.M. — Theoretical Approaches to Attachment, Early Learning and Perceptuocognitive Development (Psychoanalytic, Behaviorist, Piagetian, ethological)

TUESDAY, MAY 15 A.M. — Nursery Practicum

P.M. — Discussion of Day Care and Intervention Programs in other parts of the country and in other countries (Denmark, Russia, Israel, Czechoslovakia (film), and Greece)

MONDAY, MAY 7 A.M. — Group A - Nursery Practicum
— Group B - Newborn Nursery Placement
— Group C - Discussion of Individual Babies and their Stimulation Programs

P.M. — Development from Six Months to One Year and Stimulation Techniques

TUESDAY, MAY 8 A.M. — Nursery Practicum

P.M. — Development from 1 year to 2 years and Stimulation Techniques

WEDNESDAY, MAY 9 A.M. — Film: "Discipline and Self Control"

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P.M. — Theoretical Approaches to Attachment, Early Learning and Perceptuocognitive Development (Psychoanalytic, Behaviorist, Piagetian, ethological)

TUESDAY, MAY 15 A.M. — Nursery Practicum

P.M. — Discussion of Day Care and Intervention Programs in other parts of the country and in other countries (Denmark, Russia, Israel, Czechoslovakia (film), and Greece)

WEDNESDAY, MAY 16 A.M. —— Childhood Illnesses, Medical Problems of Infancy, Belly Button Myths and other "Old Wives' Tales", and the Young Child in the Hospital; Dr. Enrique Agorio, Guest Speaker

P.M. —— Nursery Practicum

THURSDAY, MAY 17 A.M. —— Nursery Practicum

P.M. —— Self-concept
Role-playing

NUTRITION AND THE EXPERIENCE OF EATING: INFANT AND ADULT

INTRODUCTION

This teaching unit can be used in pre-service training or in special workshops involving caregivers of young children. Plan on having either four, one hour sessions or two, half day workshops to cover all the material presented. There is a natural division between the infant, and the toddler and adult sections; a further division into psychological and nutritional needs can also be utilized.

The materials you will need for the classes are three booklets: Nutrition Scoreboard by Michael Jacobson, Scorecard for Better Eating and White Paper on Infant Feeding Practices. The Nutrition Scoreboard will be for your own reference. It includes a comprehensive discussion of nutrition and an explanation of a method for evaluating the nutritional values of various foods. Scorecard for Better Eating is a student manual and you should obtain enough copies so that each participant can have one of his/her own. All three booklets are available from the Center for Science in the Public Interest, 1779 Church Street, N.W., Washington, D.C. 20036.

It is suggested that participants keep a notebook since a number of exercises will require written notes. It is also helpful to have a blackboard available so that contributions elicited from the class can be seen by the whole group. If active participation is encouraged through the expression of feelings as well as thoughts, the sessions will be meaningful to the caregivers in a more personal way.

Food and the whole experience of eating are important parts of our lives from the time we are born. Hunger is an innate drive which triggers off one of the first social interactions a baby has with his mother, that of being fed. This social interaction and the pleasure that a child derives from the food experience contribute to his healthy and happy growth.

An increasing number of young children spend close to ten hours a day in a group care setting. Infants may receive three feedings and toddlers two meals and two snacks during this time. A large part of these children's nutritional needs and psychological needs connected with food must be met in the day care environment.

INFANT FEEDING

Psychological Needs

During the first 18 months or so of life a baby is acquiring a basic sense of trust in the environment and in the adults who care for him.[1] In this connection, discuss the value of feeding a baby when he is hungry, rather than on a schedule imposed by an adult.

The following exercise will emphasize the emotional content of the feeding process for both the baby and the person feeding the baby.

Ask the participants to think of some words to describe how they think a baby feels when he is being fed his milk. Do they

1. Erickson, Erik. Childhood and Society. Pp. 72-80.

think he feels differently if he is bottle fed rather than breast fed?[2] What are the needs that are being met by the feeding process? The participants will probably mention nourishment and the comfort of being held. They may not realize that sucking is an important need for a baby. Ask them to think of some words they might use to describe how a mother feels as she feeds her baby. Do they, as caregivers, have any of these feelings when they feed another person's baby? If any of the caregivers have children of their own, ask them if they can recall any of the feelings they experienced when they fed their babies.

Talk about how the environment can be structured to promote the best conditions for feeding. For example, are rocking chairs part of the equipment of the day care center? Ask the caregivers to suggest ways that they could help make the feeding experience for an infant a satisfying and pleasurable one. Emphasize that how a baby is fed is equally important to what he is fed. If you have access to video taping equipment or can make your own movies, it is valuable to film examples of the positive interaction that takes place during feeding such as eye contact, talking and cuddling and to show these films for comment. If you aren't able to make your own films, several scenes in the Head Start film, "Psychological Hazards in Infancy" can be shown to illustrate the lack of interaction that can take place.

During the latter part of the baby's first year, he begins to learn that he can make things happen in his environment.

2. For the advantages of breast feeding see "White Paper on Infant Feeding Practices", Center for Science in the Public Interest. Pp. 2-9.

Allowing a baby to be an active participant in his own feeding by introducing finger foods and by giving him a second spoon with which to experiment, contributes to his feeling of competence.

Ask the class to separate into pairs for role playing. Have one person act as the caregiver and the other pretend to sit in a feeding table and assume the baby's part. Use actual food and ask the persons who are playing the babies' parts to do the things a 9-15 month old baby would do, such as reach for the spoon, mash the food up with his fingers, become cranky, stand up in the feeding chair and spit food out or refuse it altogether. (After a few minutes have the participants reverse roles.) Do they feel annoyance or anger toward the baby who doesn't want to eat? How do the babies feel? How do the caregivers handle these behaviors?

It is important to help participants with their own feelings as well as the baby's. A baby who doesn't want to eat may not satisfy the nuturing need of the person who is trying to feed him. Caregivers who come to realize that a baby's appetite may lag considerably when he is around one year old and who understand their own feelings about his eating habits will be able to deal with the baby's behavior more effectively.

Nutritional Needs

There is a growing conviction among nutritionists and other health professionals that there are important disadvantages to the premature feeding of solid foods to infants. In fact, many pediatricians advise that milk alone is necessary for good nutrition for the first 4-6 months. Issues such as overfeeding,

which may be a contributing factor to later obesity, and the unnecessary dependence of most parents on commercial baby foods should be discussed.

Have a variety of baby foods available for examination. Have the teachers read or list the main ingredients of jars of meats, vegetables and fruits and to note whether or not there is any way of telling how much of each ingredient is contained in the product. Have a food blender available along with fresh apples and bananas. Ask the teachers to make their own strained baby food from the fresh fruit and to time how long it took them to make it. Have figures available to demonstrate the difference in cost between the commercial and teacher-made fruit. Besides cost, what other differences are there? The teachers will probably state that "homemade" food contains no water, sugar or other non-nutritious ingredients. Vegetables such as canned yams or beets, freshly cooked carrots or frozen cooked squash and meats such as chicken, beef or pork can be easily made into baby foods and the costs compared to the commercial products.

Ask the teachers to read pages 10-16 of the "White Paper on Infant Feeding Practices" or read portions aloud. Then discuss questions such as, "What are some of the ingredients in combination foods such as turkey and rice with vegetable" and "What does the addition of modified starch or sugar do to the nutritional value of food." Knowledge of the meaning of "empty calories", which provide no protein, vitamins or minerals, is important in order for the caregivers to judge the relative value of foods.

Practical Considerations

Parents may furnish infant formulae or if refrigeration space is limited, the day care center can provide pre-bottled infant formulae which can be kept in an area accessible to mothers and teachers. As long as babies are fed in one's arms, glass bottles do not constitute a danger unless they are left around the nursery within the reach of toddlers. As babies become old enough to hold their own bottles, plastic bottles should be used instead of glass ones, since babies tend to throw and drop them.

TODDLERS AND ADULTS

Psychological Needs

One important concept which needs to be stressed to caregivers and parents alike is that mealtimes are social experiences. Ask the caregivers to list the conditions under which they enjoy their meals. Do they like to eat alone or with others? What happens if there is tension at their dinner table? Do they like to hear music while they eat? What kind of music? What do they like to do after they eat?

Ask the caregivers if they know anyone who has a problem with overeating. Can they relate this to being rewarded for "good" behavior with food when they were children or being considered a "good" boy or girl if they ate what was expected of them.

Ask the caregivers to try to recall any childhood memories of their food experiences. Can they link any of their adult food habits to their earlier lives? What about their food preferences? Have them make two lists; one of food preferences and one of foods

they dislike. Do they remember how they cam to dislike a particular food? Can they remember how they came to like any food they formerly disliked?

Emphasize that one of the important factors in providing highly nutritious foods for very young children is the liklihood of their developing preferences for these foods or at least acceptance of these foods as they grow up.

In preparation for the next class, ask the caregivers to note statements that they hear on television relating to food and to bring them to the next session for discussion by the group.

Nutritional Needs

There is no doubt that good nutrition is important to all human beings. There is ample evidence that malnutrition affects mental as well as physical development. Poor nutrition can contribute to a lack of energy, make a person's skin and hair unattractive, lower resistance to disease and result in obesity.

Then, why are so many people in this country malnourished?[1] The first reason is that many people do not have money for enough food and certainly not for the most nutritious foods. If eating is a matter of survival, all the facts about good nutrition are secondary in importance and won't even be heard, much less heeded. As Margaret Mead said when she spoke before the Senate Select Committee on Nutrition and Human Needs "People don't eat nutrition. They eat food."

1. For references to the statistics concerning malnourishment refer to U.S. Department of Agriculture Survey, 1965 and The Ten State Nutrition Survey by the Department of Health, Education and Welfare.

Recent studies in Guatamala show physical and mental health gains of children who were simply given a dietary supplement to increase their caloric intake. The usual diet of these villagers was so poor even in caloric content that this supplement was enough to cause significant changes.

The second reason is that malnutrition is also caused by eatting too many wrong foods such as, sugar, starch, alcohol and fat.

Ask the caregivers to think of where they have receive most of their nutrition information? Did they learn about food in school? They might recall learning about the four basic food groups. What role do television commercials play in our choice of foods? Can consumers rely on the accuracy of the information provided by food manufacturers?

Discuss the notations the teachers made in the interim between the last session and this class concerning references to food on television.

Distribute copies of Scorecard for Better Eating by the Center for Science of the Public Interest. Teachers will be able to see at a glance which foods are "good foods" and which are "bad foods". These ratings are based on a formula which gives:

plus values to

- -protein
- -naturally occuring sugars
- -starch
- -unsaturated fats as in vegetable oils
- -5 vitamins (A, B-1(or B-6), B-2, Niacin and C)
- -iron, calcium and trace minerals
- -bulk

and minus values to

-added sugars and corn syrup

-saturated fats as in meats and dairy products

-a fat content above 20% of the food

Go over each scorecard list individually (vegetables, fruits, snacks, meats, etc.). Have the caregivers choose at least three foods on each list that they prefer from the ones given high values. In this way, they will be able to see that a person doesn't necessarily have to eat foods that they don't like in order to have a nutritious diet.

Ask the caregivers to evaluate their previous day's food consumption by rating each food so that they come up with a total for the day. Could they have substituted one vegetable for another they like just as well and come up with a higher rating? Which "bad foods" would they be willing to eliminate from their diets: which foods could they limit? Discuss the reasons some foods such as jello, hot dogs, cookies and soda pop get either low or negative ratings?

With the acceleration of the rate of food processing in this country, more and more additives are being used. Although most additives are entirely safe, some are hazardous. The use of sodium nitrite to preserve and color meats is considered to be potentially dangerous by many scientists. The nitrite can combine with chemicals in the meat, forming nitrosamines. A very small amount of nitrosamine has been shown to cause cancer in animals.[1] Bacon, bologna, hot dogs, canned ham, packaged luncheon meats and even one variety of toddler ham dinner contains sodium

1. Jacobson, Michael. Nutrition Scoreboard. P. 53.

nitrite. The teachers will probably be interested to know that many of the packaged sausages do not contain nitrites and can be substituted for bacon or canned ham.

A discussion of the use and effects of food coloring will be a natural lead into talking about children's food allergies. If any of the babies cared for are on special diets, it will be helpful to refer to their special needs. The older a baby is when solid food is introduced, the less likelihood there is of his developing an allergy. This is another reason for not starting solids too early. Caregivers will probably be interested to learn that protein found in milk, fish, cereal, chocolate, citrus fruits and corn are among the foods that are likely to cause an allergic reaction in a sensitive baby.

Food as a social experience can be re-emphasized when toddler feeding is discussed. Ask the caregivers what they do when toddlers spill foods. How do they encourage the use of the spoon, without using any negative messages? What are the advantages of introducing a new food gradually? They may mention that a child will be more likely to accept a new food if it is offered a little at a time. You may also point out that gradual introduction causes less likelihood of allergic reaction to food and that if an allergy does occur, it would be much easier to isolate the offending food.

How can caregivers use mealtime as a learning time? Babies are helped in their language development when words are used in connection with experiences that are important to them. Eating is one of these experiences. Caregivers have good opportunities

to label the foods the child is eating, repeat the words connected with mealtimes such as, "bib", "spoon" or "snack time" and along with gestures and facial expressions, communicate with the baby about the feelings he is experiencing such as, hunger or satisfaction. Caregivers will probably contribute other examples of learning opportunities such as the use of the hands to manage finger foods or the personal-social growth that occurs through the feeding process.

If possible, have the caregivers take turns preparing the toddler lunch for a day. Ask them to create their own daily menu from the foods they prefer, taking into account their suitability for young children and the advisability of selecting foods with high nutritional values.

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SOURCES OF FILMS SHOWN DURING OUR

FAMILY DEVELOPMENTAL CENTER

FILM FESTIVAL

JUNE 25 & 29, 1973

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I.	MODERN TALKING PICTURES 16 Spear Street San Francisco, Calif. 94105	1) "Jenny is a Good Thing" 2) "Emotional Ties in Infancy" 3) "Learning to Learn in Infancy"
II.	N.Y.U. FILM LIBRARY 26 Washington Place New York, N.Y. 10003	1) "A Two Year Old Goes to the Hospital" 2) "Bathing Babies in Three Cultures"
III.	TIME-LIFE FILMS, INC. 43 West 16th Street New York, N.Y. 10011	1) "Rock-A-Bye Baby"
IV.	McGRAW-HILL FILMS 330 West 42nd Street New York, N.Y. 10036 Tel: (212) 997-1221	1) "From Cradle to Classroom: Parts I & II"
V.	U.C. EXTENSION MEDIA CENTER 2223 Fulton Street Berkeley, Calif. 94704	1) "Mother Love" 2) "Growth Failure and Maternal Deprivation" 3) "Learning About Learning"
VI.	UNIVERSITY OF ILLINOIS MOTION PICTURE SERVICE 1007 West Nevada Street Urbana, Illinois 61801	1) "Ordinal Scales of Infant Psychological Development" By Uzgiris and Hunt
VII.	JOURNAL FILMS, INC. 909 West Diversey Parkway Chicago, Illinois 60614	1) "Mothers and Toddlers"

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Catalogs from the above sources can provide you with descriptions of additional films which may be relevant to your program.

FAMILY DEVELOPMENTAL CENTER

FILM SCHEDULE: Monday, June 25 and Friday, June 29, 1973

Room #2		Room #3		Room #4	
1:00	Jenny is a Good Thing	1:00	Bathing Babies in Three Cultures	1:00	Growth Failure and Maternal Deprivation
1:45	Two-Year-Old Goes to the Hospital	1:30	Rock-A-Bye Baby	1:45	Mother Love
3:30	Ordinal Scales of Infant Psychological Development: #1 - Object Permanence #2 - Development of Schemas	2:15	Mothers and Toddlers	2:30	Emotional Ties in Infancy
4:45	Learning About Learning	3:30	Cradle to Classroom: I & II	3:30	Our Babies
5:30	Bathing Babies in Three Cultures	4:45	I'm 17, Pregnant and Don't Know What to Do	4:00	Two-Year-Old Goes to the Hospital
6:00	Rock-A-Bye Baby	5:30	Rock-A-Bye Baby	5:30	Mothers and Toddlers
6:45	I'm 17, Pregnant, and Don't Know What to Do	6:15	Mother Love	6:15	Growth Failure and Maternal Deprivation
		7:00	Growth Failure and Maternal Deprivation	7:00	Jenny is a Good Thing

00119

FILM NOTES

Jenny is a Good Thing Head Start film with emphasis on nutrition in early childhood. Award winning color film narrated by Burt Lancaster. 30 min.

Two-Year-Old Goes to the Hospital British film in two parts. Made by the Robertsons who have worked at the Tavistock Clinic and have done much work involving separation of mother and child. 50 min.

Bathing Babies in Three Cultures Varying cultural patterns in New Guinea, U.S. in 30's and 40's and Bali. Made and narrated by Margaret Mead in 1947. Classic anthropology film. 10 min

Mothers and Toddlers Film of the Martin Luther King toddler nursery, Chicago, Ill. 30 min.

Learning About Learning Recent advances in the field of learning and the work of some psychologists, incl. Skinner and Harlow.

FILM NOTES (continued)

Ordinal Scales of Infant Psychological Development Demonstration of some procedures used to administer the scales developed by Uzgiris & Hunt, and concrete illustrations of behavioral phenomena described by Piaget.40 & 36 min.

Growth Failure and Maternal Deprivation The stimulation program in a Detroit hospital for 2 severely deprived children aged 15 mos. and 4 years.

Emotional Ties in Infancy Head Start film showing the importance of a personal relationship from the earliest age.

I'm 17, Pregnant, and Don't Know What to Do. Filmed in the Bay Area. Issues faced by a pregnant girl and how one agency helps her make these decisions. Very realistic film.

Rock-A-Bye Baby Award-winning film showing methods of child rearing in different cultures, especially in the area of kinesthetic stimulation. Babies from Africa and Guatemala are featured.

Cradle to Classroom: I & II CBS 21st Century film showing innovations in early childhood learning. Walter Cronkhite narrates. Color.

Mother Love Dr. Harry Harlow's experiments with monkeys showing the effects of maternal deprivation and the importance of the comfort received from the mother figure.

Our Babies Some scenes of Family Developmental Center babies at play.

00120

VISITORS TO FAMILY DEVELOPMENTAL CENTER AND INFORMATION DISSEMINATED: JUNE 1973-1975

VISITORS TO FAMILY DEVELOPMENTAL CENTER AND INFORMATION DISSEMINATED: JUNE 1973-1975

Over the four years of our operation, many persons have expressed an interest in learning about our program. Since we moved into our permanent facility two years ago, we have had hundreds of visitors and many staff hours have been spent in sharing our experiences with them. When possible, we try to see visitors in samll groups so as to make the maximal use of staff time, but we nave also accomodated our schedules to allow for many individual visits.

Our basic presentation includes an orientation by a staff member outlining our history, goals and program followed by a question and answer period. One or two visitors at a time are allowed to tour the nursery area, to observe activities and ask more questions. A list of visitors and the information disseminated to them follws. Groupings are made according to geographic location.

SAN FRANCISCO, CALIFORNIA

NAME	AFFILIATION	DATE	INFORMATION GIVEN
Hannah Saules & Gregory Rankin	Hastings Law School, Child Care Center, 198 McAllister St., San Francisco	12/13/72	Basic presentation & given film list, exercises for babies and material for staff training
Helen Valdez	Mission Adult Center, 19th & Capp Sts, San Francisco	5/8/73	Basic presentation
Dr. Steveanne Auerback-Fink, Day Care Specialist	190 Amber Drive, San Francisco	7/73	Basic presentation
Jennifer Guitierrez, Ph.D.	Department of Obstetrics & Gynecology, San Francisco General Hospital, 1001 Potrero Ave., San Francisco	8/10/73	Basic presentation
Lauren Santora, student	City College, 50 Phelan Ave., San Francisco	10/5/73	Basic presentation; visit related to class, Home Economics 58 - The Child, The Family & The Community

NAME	AFFILIATION	DATE	INFORMATION GIVEN
Ginny Ryan, Graduate Student in Early Childhood Education	San Francisco State University, 1600 Holloway, San Francisco	10/18/73	Basic presentation & information on normal development
Mary Manhart, student class in Community Service	San Francisco State University, 1600 Holloway, San Francisco	11/23/73	Basic presentation & information on normal development
Kay King, Head Teacher	Florence Crittenden Center, 850 Broderick St., San Francisco	11/15/73	Basic presentation & observed individual stimulation programs
		Fall '74	Gave information about examing paper for changing tables
		Fall '75	Sent copies of menus at her request
		5/5/75	Given copy of FDC Medical Procedure Manual for Young Children to be used in teenage parent training
Steven & Sonja Boyd	Lutheran Care for the Aging, 1101 O'Farrell St., San Francisco	1/17/74	Basic presentation; information was acquired for insertion in a Resource Manual for referrals from various Lutheran congregations in San Francisco
Werner Erhard, Director	E.S.T. (Erhard Training Seminar, San Francisco	1/24/74	Basic presentation
Dorothy Robertson	George Peabody School, SFUSD, 250 7th Ave., San Francisco	1/30/74	Basic presentation & extended observation in nursery
Cadet Pat Boone	The Salvation Army School of Officers' Training, 1450 Laguna St., San Francisco	2/13/74	Basic presentation

NAME	AFFILIATION	DATE	INFORMATION GIVEN
Carol Pogasn, reporter	San Francisco Examiner, 110 5th St., San Francisco	3/74	Given information about the program for a future article & photographer allowed to take photos.
Vicky Lilenthal	San Francisco State University, South San Francisco Adult Education, Parent-Child Observation Program, Tamarach & Spruce Sts., South San Francisco	3/6/74	Basic presentation. Planning to add a teen-age mother program to their classes. Interested in the facility (physical set-up of a nursery), format of the program & composition of staff members.
Martha Roditti	Childcare Switchboard, 3869 24th St., San Francisco	3/74	Basic presentation.
Lenwood Homel	San Francisco Unified School District, 135 Van Ness Ave., San Francisco	4/29/74	Basic presentation & extended observation period in the nursery.
Mary Wasson, student	San Francisco State University, 1600 Holloway Ave., San Francisco	5/1/74	Basic presentation & given information on normal development.
Christine Derby & Colleen Harrington, students	University of San Francisco, Golden Gate & Parker Aves., San Francisco	4/74	Basic presentation & three days of observation in the nursery. Primarily interested in normal growth and development since previous experience had been with sick children.
Peter Higgins	Board of Education, San Francisco Unified School District, 135 Van Ness Ave., San Francisco	5/74	Basic presentation.
Patricia Van Buskirk	Lone Mountain College, Graduate Program-Community Development	5/2/74	Basic presentation.

NAME	AFFILIATION	DATE	INFORMATION GIVEN
Eileen Babb	John Hale Mental Health Services, 4301 3rd St., San Francisco	5/74	Basic presentation & spent a morning learning about how to run an infant center. Brought back a group she was training to become Mental Health Aides.
Eileen Babb, Corleen Gray, Deborah Mc Allister, Apri Duhan	John Hale Mental Health Services, 4301 3rd St., San Francisco	5/15/74	Basic presentation & individual observations in nursery with teachers.
Linda Gordon, Seretta J. Marshall, Victor Mayo, Cerella Lucas, M.D.	John Hale Mental Health Services, 4301 3rd St., San Francisco	5/22/74	Basic presentation & individual observations in nursery with teachers.
Robert Reel, Social Worker	Human Resources Development, California St., San Francisco	5/74	Basic presentation.
Cathy Stein, graduate student in Nursing	University of California, San Francisco	5/22/74	Basic presentation.
Robert Morgan, Acting Dean	California School of Professional Psychology, 480 Potrero Ave., San Francisco	Spring, 1974 Fall, 1974	Basic presentation. Information requested regarding architects & the atmosphere of the area in which the facility is located.
Tricia Faust, Graduate Student in Child Development	San Francisco State University, 1600 Holloway Ave., San Francisco	Spring, 1974	Basic presentation & at least 10½ days spent at Center in order to learn observation & stimulation techniques to help her in home visit program she was setting up. Given references for bibliography for her term paper.

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SAN FRANCISCO

NAME	AFFILIATION	DATE	INFORMATION GIVEN
Elba Montes Tuttle	Puerto Rican Women's Organization, 1156 Florida St., San Francisco	8/74	Upon request lent them cribs, cots and other children's furniture and toys for use during their annual conference in the Far West Building.
Susan Edwards	Bay Guardian, 1070 Bryant St., San Francisco	9/6/74	Basic presentation & given information needed for article on day care ficilities in San Francisco.
Mary Williams & Digna Bustillo	University of California, Medical Center, 400 Parnassus Ave., San Francisco	9/6/74	Basic presentation.
Candy Benton	Mission Mental Health, 449 Ellsworth St., San Francisco	9/17/74	Basic presentation
Evelyn Brann	San Francisco Unified School District, 135 Van Ness Ave., San Francisco	9/19/74	Basic presentation & extended observation period in nursery.
Vicki Strang, Director	Children's Council	10/74	Basic presentation
Isadore Pivnick, Supt., of Elementary Education, SFUSD Christine Simmons, Director, Childrens' Centers, Madeline Halprin, Program Director, Childrens' Centers	San Francisco Unified School District	10/17/74	Basic presentation & extended observation in nursery.
Shirley Reece, Clinical Social Worker, Lecturer, Dept. of Psychiatry	Langley Porter Institute, University of California, 400 Parnassus Ave., San Francisco	10/31/74	Basic presentation & discussion with Project Director & Nursery Coordinator relating to psychiatric needs of adolescent mothers.

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SAN FRANCISCO

NAME	AFFILIATION	DATE	INFORMATION GIVEN
John Alston, M.D.	Fellow in Child Psychiatry, Children's Services	10/31/74	Basic presentation & discussion with Project Director & Nursery Coordinator relating to psychiatric needs of adolescent mothers.
Jerry Dodson, M.D.	Fellow in Child Psychiatry on assignment from LeHerman General Hospital	10/31/74	Basic presentation & discussion with Project Director & Nursery Coordinator relating to psychiatric needs of adolescent mothers.
Margaret Edwards, MSW.	Children's Services	10/31/74	Basic presentation & discussion with Project Director & Nursery Coordinator relating to psychiatric needs of adolescent mothers.
Joseph Greene, M.D.		10/31/74	Basic presentation & discussion with Project Director & Nursery Coordinator relating to psychiatric needs of adolescent mothers.
Lowell Kallen, M.D.		10/31/74	Basic presentation & discussion with Project Director & Nursery Coordinator relating to psychiatric needs of adolescent mothers.
Edward Merves, M.D.& Miles Yeagley, M.D.	Fellow in Child Psychiatry on assignment from LeHerman General Hospital	10/31/74	Basic presentation & discussion with Project Director & Nursery Coordinator relating to psychiatric needs of adolescent mothers.
Brian Flannery	Mission Child-care Center, 2922 Mission Street, San Francisco	11/05/74	Mainly interested in facility, as he was searching for appropriate space for their child care center. Discussed specific architectural considerations

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SAN FRANCISCO

NAME	AFFILIATION	DATE	INFORMATION GIVEN
Evelyn Meyer	California School of Professional Psychology, 480 Potrero Ave., San Francisco	11/6/74	Basic presentation
Marlene Becking, Ph.D., Instructor	California School of Professional Psychology, 480 Potrero Ave., San Francisco	12/74	Basic presentation
Judy Brown	Early Childhood Division, Far West Lab, San Francisco	9/17/74	Basic presentation plus information on lisencing requirements.
Richard Brown, M.D., Director	Adolescent Medicine Children's Hospital 3700 California St., San Francisco	12/4/74	Basic presentation & discussion of individualized programs for each child. Also discussed parent participation & some conclusions we've drawn.
Wanda Long, MSW	Adolescent Medicine Children's Hospital 3700 California St., San Francisco	12/4/74	Basic presentation & discussion of individualized programs for each child. Also discussed parent participation & some conclusions we've drawn.
Byron Aoki, M.D.	Adolescent Medicine Children's Hospital 3700 California St., San Francisco	12/4/74	Basic presentation & discussion of individualized programs for each child. Also discussed parent participation & some conclusions we've drawn.
Michael Weiss, M.D.	Adolescent Medicine Children's Hospital 3700 California St., San Francisco	12/4/74	Basic presentation & discussion of indivdualized programs for each child. Also discussed parent participation & some conclusions we've drawn.

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SAN FRANCISCO

AME	AFFILIATION	DATE	INFORMATION GIVEN
tanley Chow	Deputy Director of Early Childhood Section Flexible Learning Systems, Far West Lab, 1855 Folsom St., San Francisco	12/4/74	Exchange of information in regard to FDC grant proposal for Infant Special Education Project
ack Giuliani	California School of Professional Psychology, 480 Potrero Ave., San Francisco	2/25/75	Basic Presentation
dison Uno	California School of Professional Psychology, 480 Potrero Ave., San Francisco	2/21/75	Basic presentation
usan Jacobs, oard Member	Family Service Agency 1010 Gough Street Francisco	1/13/75	Basic presentation
renda Minich, aura Walker	Dawn Horse Communion Group, 795 Buena Vista West, San Francisco	2/75	Basic presentation & given specific activities that are appropriate for young babies in preparation for admitting infants to their day care center
essie Stewart, tudent	San Francisco State University, 1600 Holloway Ave., San Francisco	3/5/75	Basic presentation
. Robert Howden, h.D., Associate irector	Institute for Community Relations Research, University of San Francisco, School of Education Golden Gate & Parker Avenues, San Francisco	3/5/75	Basic presentation
tephen Marena, up't. of Schools, sadore Pivnick up't. of Elementary Education	San Francisco Unified School District, 135 Van Ness Ave., San Francisco	3/7/75	Tour of facility

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SAN FRANCISCO

NAME	AFFILIATION	DATE	INFORMATION GIVEN
Father Reed	Commissioner, SFUSD Board of Education	3/7/75	Tour of facility
Sally Flinn, Helen Rubin	John Swett School, San Francisco Unified School District 135 Van Ness Ave., San Francisco	3/21/75	Basic presentation
Betty Foote	Setting up private day care center for 2½ yr.-5 yr. olds in Mission area	3/10/75	Basic presentation plus information regarding lisencing requirements
Rosario Bacon, MSW	St. Luke's Hospital Center, 27th St., & San Jose Ave., San Francisco, CA 94110	1/16/75	Basic presentation ; tour with several mothers and given application materials.
Sandy Lindsey, MSW	San Francisco General Hospital, Hilltop Center - Ward 35, 23rd & Utah St., San Francisco, CA 94110	1/17/75	Basic presentation; several tours for mothers and given application materials.
Mr. McIntyre, counselor	Mission High School, 701 Frederick San Francisco, CA 94117	4/29/75	Attended counselor's meeting; given program description & eligibility requirements.
Judy Bebelar, counselor	Opportunity High School, 160 S. Van Ness, San Francisco, CA	4/29/75	Attended counselor's meeting; given program description & eligibility requirements.
Malva Blosser, student counselor	San Francisco General Hospital, 1001 Potrero Ave., San Francisco, CA	4/29/75	Attended counselor's meeting; given program description & eligibility requirements.
Stanley Whitehead, Project Director	Mission Rebels in Action, 674 S. Van Ness Ave., San Francisco, CA 94110	5/15/75	Basic presentation & referral information

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CALIFORNIA EXCEPTING SAN FRANCISCO

NAME	AFFILIATION	DATE	INFORMATION GIVEN
Camille Kirkham	Calico Cat Day Care Center, 1337 Cornell, Berkeley, California	12/1/72	Basic presentation
Carl Shelton	Berkeley Head Start Program, Good Shepard Church, 9th & Hearst Sts., Berkeley, California	5/8/73	Basic presentation
Dorothy Shack, Lottie Rosen	Early Growth Center, 1720 Oregon Street, Berkeley, California	5/8/73	Basic presentation
Mary K. Maples	Family Service Agency of Santa Rosa, 223 Kentucky St., Petaluma, California	6/73	Basic presentation & exchange of reference materials. Director, Nursery Coordinator and Social Worker had lunch with her.
Irene Galazan, teacher in 24 hour care of infants	Synanon Foundation, Inc. Box 786, Marshall, California	8/8/73	Basic presentation & given copies of staff training material & observed in nursery all day. Gave our staff an in-service training session on her child care center program.
Opal L. Massey, Jovine Hankins, PHN & Jean-Paul Schreter, Superintendent	Oakland Public Schools, 1025 2nd Ave., Oakland, California	2/6/74	Basic presentation, were attempting to obtain funding to set up an infant center in connection with the school.
Fourteen students	Merritt Child Development Center, Merritt College, 12500 Campus Dr., Oakland, California	4/16/74	Basic presentation
Sister Ann Maureen	St. Vincent's Day Home, 1086 8th St., Oakland, California	4/22/74	Basic presentation
Virgil S. Hollis, Superintendent	Marin County Schools, Marin County, California	4/22/74	Basic presentation

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CALIFORNIA EXCEPTING SAN FRANCISCO

NAME	AFFILIATION	DATE	INFORMATION GIVEN
Senator Milton Marks with staff members and press	State Capitol, Sacramento, CA	4/26/74	Basic presentation
Para Gaston	Creative Youth Opportunity, 1548 West 85th St., Los Angeles, CA	4/26/74	Basic presentation & given copies of stimulation programs, film list, copies of infant exercises. Asked Director & Nursery Coordinator to visit L.A. and show movies of FDC program and speak to a regional group that was meeting there next week; this was unfeasible.
Lynn Steinman, Julie Garcia, Gene Medinnis & Wilma Trace	Los Pequenitos Infant Care Center, 359 N. 4th St., San Jose, CA	5/24/74	Basic presentation & given copies of infant stimulation programs & given extended nursery observation.
Melinda Martin, Director	Albany Children's Center, 1140 9th St., Albany, CA	5/29/74	Basic presentation
Senator George Mascone with staff member Angelita Alarcon and press	State Capitol, Sacramento, CA	7/74	Basic presentation
Joan Schurr	Stockton Unified School District, 2202 N. Pershing Ave., Stockton, CA	8/29/74	Basic presentation
E. Holman, M. Kelsey & L. Butler	Vallejo City School District, 211 Valle Vista, Vallejo, CA	9/13/74	Basic presentation
Kathy Abraham & Loretta Wilkerham	San Ramon Valley Unified School District, Sycamore Valley Rd., Danville, CA	11/7/74	Basic presentation

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CALIFORNIA EXCEPTING SAN FRANCISCO

NAME	AFFILIATION	DATE	INFORMATION GIVEN
Mary Somers	Peninsula High School, 600 Columbia, San Mateo, CA	11/12/74	Basic presentation & gave equipment list, copies of stimulation programs, forms showing daily schedule, FDC medical manual, information regarding legislation in relation to infant day care funding, staff training materials. She was setting up infant day care program for teen-age parents in high school.
Davna Kimbell & Janet Morales	University of California, Davis, CA	11/22/74	Basic presentation
Ellie Baumann	Visitation Valley Family School, 50 Raymond, Visitation Valley, CA	12/17/74	Basic presentation
Ed Recking, Ph.D.	Peninsula Hospital, Burlingame, CA	12/74	Basic presentation
Marlene Posner, Child Care Consultant	Contra Costa County, 2380 Smith Lane, Concord, CA	2/13/75	Basic presentation
Chong Son Kim	San Jose State University, Department of Home Economics, San Jose, CA	3/6/75	Basic presentation
Bob Cover	E.C.E. Coordinator, Tracy, CA	3/7/75	Basic presentation
Sarah Cole	Fountainhead Montessori, 24 Orinda Way, Orinda, CA	3/7/75	Basic presentation
Gail Shafarman	Office of Community Child Care Telegraph Ave., Berkeley, CA	3/7/75	Basic presentation
Al Willey	El Dorado County Office of Education, 337 Placerville, Ca	3/18/75	Basic presentation & given information regarding Bayley Developmental tests.

INFORMATION DISSEMINATION

CALIFORNIA EXCEPTING SAN FRANCISCO

NAME	AFFILIATION	DATE	INFORMATION GIVEN
Madge Gerber, Director Ronda Garcia	Mother-Infant Project, Palo Alto, CA	3/75	Basic presentation extended observation in nursery.
Catherine Maddox	New Futures School, 110 Broadway, N.E., Albuquerque, N.M.	5/19/75	Basic presentation

FAMILY DEVELOPMENTAL CENTER

INFORMATION DISSEMINATED

AREAS OUTSIDE OF SAN FRANCISCO AND CALIFORNIA

NAME	AFFILIATION	DATE	INFORMATION GIVEN
Dr. Charles M. Butter Professor	Dept. of Psychology, University of Michigan, Ann Arbor, Michigan	5/73	**Basic presentation**
Dr. Irene Butter Consultant	Health Manpower Project, World Health Organization, Children's Division	5/73	**Basic presentation**
Anne G. Dorsey	Arlett Child Development Center, 2535 Dennis St., Cincinnati, Ohio	5/15/73	Basic presentation
Wendell C. Robinson	Black Child Development Institute, 1028 Connecticut Ave. N.W., Washington, D.C.	4/26/74	Basic presentation
David Judd	Nero & Associates, 208 S.W. Stark, Portland, Oregon	5/15/74	Observation of facility and Center operation. Has USDE grant to study "Follow Through" models
Helene Van Zyl	Pikkieland Creche & Nursery School 424 19th, Villieria Pretoria, South Africa	5/17/74	Basic presentation
Paulette Bass	Teen Pregnancy Center, 2050 Whitfield Mills Rd., Jackson, Mississippi	6/22/74	Came on a visit from Mississippi specifically to visit our program after making appropriate arrangements in advance. Basic presentation & spent two days observing all aspects of the Center operation, including infant testing. We arranged a visit to the Special Service Centers at San Francisco General Hospital. We gave her film lists, copies of stimulation programs, staff training manuals, & infant exercises.

INFORMATION DISSEMINATED

AREAS OUTSIDE OF SAN FRANCISCO AND CALIFORNIA

NAME	AFFILIATION	DATE	INFORMATION GIVEN
Bonnie Kinsley & Beth Okerson	School Age Mother's Program, 2 Washington St., Worcester, Massachusetts	8/29/74	Basic presentation & discussion with Health Director regarding health and behavior problems in the Nursery. Also interested in the educational component for the mothers.
Dr. Miryam Davis, Director	Perinatal Treatment Program, Narcotics Treatment Administration, Washington, D.C.	9/74	Basic presentation.
Anthony Locke, Warden	Toynbie Hall, London England, Psychological Center	10/74	Basic presentation
Dr. George T. Lodge, Director	Old Dominion College, Norfolk Virginia	11/74	Basic presentation
J. Ronald Lally	Family Development Research Program & Syracuse University's Children's Center, College for Human Development, Syracuse University, Syracuse, New York	1/7/75	Basic presentation
Richard T. Hoare,	Staples School System, 524 N. 3rd St., Staples, Minnesota	2/10/75	Basic presentation & given information on staff training, a bibliography relevant to infant stimulation.
Ron Byrne	Carr, Byrne & Associates (architects), 143 Fullarton Rd., Rose Park, South Australia (commissioned by Australian government to study childhood services in California, England, Sweden	3/75	Basic presentation & allowed to take pictures of the facility; given a copy of the architect's floor plan given information on lisence requirements

INFORMATION DISSEMINATED

AREAS OUTSIDE OF SAN FRANCISCO AND CALIFORNIA

ME	AFFILIATION	DATE	INFORMATION GIVEN
L. Shanks	Research Psychologist, Children's Hospital, National Medical Center Washington, D.C.	4/1/75	Basic presentation
nelope P. Royce	Child Care Services Division, Dept. of Human Resources, State of Nevada	6/23/75	Basic presentation

MOTHER-CHILD INTERACTION

MALE BABY A

Notes at time of 3 month test

Vocalizations

Mother appears to have little confidence in her relationship with the baby. When asked to see if she could get him to talk, she said, "He won't talk for me. He only talks for my mother." Later after the baby started fussing, she said, "See, he always cries when I talk to him." The mother talked to the baby in an adult way as if he could understand her fully. This doesn't mean that she has unrealistic expectations.

Eye-Hand Coordination

The mother placed the three-ball rattle in the baby's hand. When asked if the baby had any rattles at home, the answer was "no." There was very little interaction other than placing the toy.

Gross Motor

Mother placed the baby on his side to demonstrate his turning to his back. Baby became cranky about 15 minutes after testing started. The mother had no reaction to baby's fussiness. When asked when he ate, she replied 12:30 (it was 1:45). I gave her some water for him. She fed him the water (no burping) and he stopped fussing.

The baby is supposed to have minor surgery tommorrow (Thursday). The mother felt that perhaps he wouldn't be allowed outdoors afterwards and so she wouldn't bring him into the Center until Monday. (She didn't follow through on this appointment.)

MOTHER-CHILD INTERACTION

MALE BABY B

Notes at time of 6 month test

Vocalizations

The mother repeated the syllables the baby was making several times...shook him a little...looked into his face. The baby made two sounds that he hadn't made before the mother attempted to get him to vocalize.

Gross Motor

The mother said that the baby could not crawl and when she was asked to put him on the floor, she was a little hesitant (but did). I encouraged him verbally several times. She seemed to get pleasure from baby's attempts. The mother was given a toy to use in motivating the baby. The baby moved a couple of inches to get it. The mother then took the toy and moved it further up. She was surprised that the baby crawled one foot to get the toy.

Learning

The mother made several attempts to get the baby to look for the toy under a cloth. When the cloth was not quite covering the toy, she started the whole procedure over.

She said "He gets mad when he wants something and he can't get it. He gets impatient." She has a soothing voice when the baby gets upset.

Visual Exploration

The mother did not make much of an attempt to get the baby to look at the pictures. She did not name any pictures, but turned the page a few times. Not much talking to the baby. The baby was not interested in the book.

Eye-Hand Coordination

Not much verbalization. Mother demonstrated several times. Moved toy close to the baby after it was knocked away. Baby was able to play with the toy by pushing it. General tone was satisfaction with the baby. She laughed at the baby's behavior quite a bit. Seemed to underestimate baby's abilities. (He can't crawl yet and he's too young for books).

MOTHER-CHILD INTERACTION

FEMALE BABY C

Notes at time of 9 month test

Visual Exploration

Mother points, "Look, see the shoes...like your shoes. Look down here." Baby was not looking. Mother laughs, "What is that?"

Mother slants book so that baby's line of vision falls on it and the baby then starts looking at the pictures. The mother lifts the page slightly..."You gonna turn it?" Baby struggles to turn the pages back. The mother watches quietly, then after several attempts on the baby's part...lifts the page part way. The baby then turns the page.

Eye-Hand Coordination

The mother gives two demonstrations. The baby grabs the toy and puts in in her mouth. The mother demonstrates again. Baby play with toy.

Learning

Baby able to find toy under cloth easily. The mother was then asked to hide tne toy under one of two boxes. She does and baby looks under wrong box. No comment. No further action. When I said that she could do it as many times as she wanted, the mother repeated the task several times. One time the boxes were too far away from the baby for her to find the toy. Another time the mother mixed up the boxes making the task too hard.

Gross Motor

The mother let go of the baby's fingers and the baby walked four steps toward her. The next time, the baby crouched down and crawled instead of walking. The mother let her crawl to the testing room

Vocalizations

The baby was vocalizing so much I couldn't see the interaction. The mother does talk to her in a soft voice.

Social Interaction

The mother placed the baby in a chair, covered her face and then uncovered it; the baby smiled. The second time she said, "Boo" softly and the baby laughed. The third time, the baby smiled. Distance about 3 to 4 feet.

MOTHER-CHILD INTERACTION

FEMALE BABY D

Notes at time of 12 month test

Visual Exploration

"Wait a minute", the mother talks in an excited voice. "Look, doggie, apple, turn the page." Baby turns the page. "Horsie, doggie and fish. Turn the next page. Fish, see, see, see. Turn the page. Come on." The mother does not seem to lose interest in showing the baby the book.

Eye-Hand Coordination

The mother stacked blocks once and urged the child one time to do the same. Not much interest in task.

After I had tried to get the baby to put 9 cubes in a cup and she had always stopped at 8; the mother, on her own, took over the task without intervening to help the baby, appropriately urging and smiling at her attemps.

Gross Motor

Mother says that she throws a larger ball. When the baby held the ball so as if to throw it, the mother was able to pick up the cue that her attention was focused on me, not her, and said that I should clap my hands (as she had done) to urge her to throw it to me.

Vocalizations

"She says head", the mother repeated the word "head" several times, pointing to her head and the baby's. Finally, the baby started pointing to her own head. She also says "ta ta" (thank you) to the baby when she wants her to give her something.

MOTHER-CHILD INTERACTION

FEMALE BABY E

Notes at time of 15 month test

Book

The mother looks for a familiar object. "Say button, say bear, oh look." Baby vocalizes. "See bus, look." Baby imitates, "bu" "there go book." Baby say "mine." "There goes another bear. Look at doggie. Point to doggie." Baby keeps saying "doggie."

Eye-Hand Coordination

Mother makes a 4 block structure. Holds baby's hands so that she won't knock it over. Mother laughs at baby's antics. Enjoys her. Back to blocks. Demonstrates many times...talks to baby continuously. "No, don't drop it. Put it on top. You're getting tired."

Puzzle

The mother states "I shouldn't point while encouraging her to put pieces in." "Fix it (baby's name). Fix it for Mommy. That one doesn't go in there."

Gross Motor

The mother was asked to see if the baby could stand on one foot. The mother took the doll, put the doll's leg up and in addition stand on one foot herself. Very animatedly gestured to doll and told baby to do like the baby.

The mother keeps demonstrating how to stand on walking board with both feet after persistent trials; the mother is patient.

Baby was involved in activity stringing pretzels on shoe lace before test. Mother sought me out. I told her the baby was busy and she stayed in activity room with her until she was through.

MOTHER-CHILD INTERACTION

FEMALE BABY F

Notes at time of 18 month test

The mother arrived with the baby in the afternoon for her test; they had been away from the Center for a week or so. The baby showed obvious pleasure at being back. She ran around, smiled and went over to ride the horse. She seemed happy to see the other children. When the mother first came in, she announced to everyone in the nursery that the baby had been potty trained while she had been home. She began asking the baby if she had to go to the potty.

After a short period, we went into the testing room and the mother held the baby for the test. I began by giving her the cubes and urged her to stack them. The baby made no attempt to stack them and pat-a-caked with them instead. The mother on her own accord urged the baby to stack the cubes, demonstrated how to stack them, and finally when she got no response, took the baby's hands and tried to make her do it, but the baby was resistent.

The baby was well motivated to attempt the pegboard. The mother on her own accord oriented the board so as to facilitate her performance and placed the pegs where she could get them easier. At the same time she distracted the baby in her performance by fussing at her and telling her not to hold all the pegs in one hand at once, to put them all down but one, etc.

The child said, "no" to the mother when she kept interfering by trying to make her do certain things. She also was heard to say, "Batman, Bobby (dog), eyes, light, baby, Mama, hi, bye and a word that she often used which sounded like "ca ca," but which the mother said was "all gone." The mother reported that she also says, "put it back."

The mother demonstrated how to go up and down the stairs by holding to the wall, but the baby did not try this way; she crawled up the stairs and then backed down on her hands and knees. The mother seemed a bit defensive about this and said that she walks up and down at home.

The baby's poorest area was in imitation. Social approval does not seem to be a reinforcer for her; she does not perform for people's approval. In fact, it seems that she may do the opposite of what is being asked in order to get negative attention. This is in keeping with the mother's teaching style. The mother does not give positive reinforcement, but does give constant negative reinforcement, by fussing, yelling and hitting the baby's hands. The baby does not pay any attention until the yelling and slapping become intense. She sometimes had tears that ran down her face from being slapped, etc., but did not cry out loud; she seemed to

pull herself together after a minute as though this was normal for her.

Even after all of this, the baby would sometimes look coyly out of the sides of her eyes at the mother and with a little smile do the opposite of what she was trying to get her to do. Once the baby slapped the mother's hands after she had been slapped and once she said, "no" to the mother when she slapped her. I had the feeling that they are always playing a game of aggravating and frustrating each other.

The mother is good at orienting materials to facilitate success and verbalizes some satisfaction from the baby's success. After the baby put in the pegs, the mother said, "you couldn't do that before." She doesn't verbalize in a positive way that the baby can interpret as approval, however. She doesn't seem to realize that her insistence on having the baby do a task in a certain way interferes with her attention and satisfaction from learning by trial and error.

During the test, the mother often asked the baby if she needed to go to the potty. She made threats of what would happen if the baby had an accident.

NAME:

DATE:

HOW I SEE MYSELF

1.	Nothing gets me too mad	1	2	3	4	5	I get mad easily and explode
2.	I don't stay with things and finish them	1	2	3	4	5	I stay with something till I finish
3.	I'm very good at drawing	1	2	3	4	5	I'm not much good in drawing
4.	I don't like to work with others	1	2	3	4	5	I like to work with others
5.	I wish I were smaller (taller)	1	2	3	4	5	I'm just the right height
6.	I worry a lot	1	2	3	4	5	I don't worry much
7.	I wish I could do something with my hair	1	2	3	4	5	My hair is nice-looking
8.	People like me	1	2	3	4	5	People don't like me
9.	I've lots of energy	1	2	3	4	5	I haven't much energy
10.	I am ignored at parties	1	2	3	4	5	I am a hit at parties
11.	I'm just the right weight	1	2	3	4	5	I wish I were heavier (lighter)
12.	Women don't like me	1	2	3	4	5	Women like me a lot
13.	I'm very good at speaking before a group	1	2	3	4	5	I'm not very good at speaking before a group
14.	My face is pretty (good-looking)	1	2	3	4	5	I wish I were prettier (good-looking)
15.	I'm very good in music	1	2	3	4	5	I'm not much good in music
16.	I get along well with teachers	1	2	3	4	5	I don't get along with teachers
17.	I don't like teachers	1	2	3	4	5	I like teachers very much
18.	I don't feel at ease, comfortable inside myself	1	2	3	4	5	I feel very at ease, comfortable inside myself
19.	I don't like to try new things	1	2	3	4	5	I like to try new things
20.	I have trouble controlling my feelings	1	2	3	4	5	I can handle my feelings
21.	I did well in school work	1	2	3	4	5	I didn't do well in school

22.	I want men to like me	1	2	3	4	5	I don't want men to like me
23.	I don't like the way I look	1	2	3	4	5	I like the way I look
24.	I don't want other women to like me	1	2	3	4	5	I want other women to like me
25.	I'm very healthy	1	2	3	4	5	I get sick a lot
26.	I don't dance well	1	2	3	4	5	I'm a very good dancer
27.	I write well	1	2	3	4	5	I don't write well
28.	I like to work alone	1	2	3	4	5	I don't like to work alone
29.	I use my time well	1	2	3	4	5	I don't know how to plan my time
30.	I'm not much good at making things with my hands	1	2	3	4	5	I'm very good at making things with my hands
31.	I wish I could do something with my skin	1	2	3	4	5	My skin is nice-looking
32.	Housework isn't interesting to me	1	2	3	4	5	Housework is very interesting
33.	I don't do my housework well	1	2	3	4	5	I do a good job at housework
34.	I'm not as smart as others	1	2	3	4	5	I'm smarter than most of the others
35.	Men like me a lot	1	2	3	4	5	Men don't like me
36.	My clothes are not as I'd like	1	2	3	4	5	My clothes are nice
37.	I like school	1	2	3	4	5	I don't like school
38.	I wish I were built like others	1	2	3	4	5	I'm happy with the way I am
39.	I don't read well	1	2	3	4	5	I read very well
40.	I don't learn new things easily	1	2	3	4	5	I learn new things easily

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HOW I SEE MY BABY*
(Preliminary Form)

1.	Baby is usually good-natured and happy	1 2 3 4 5		Baby is usually fretful and cranky
2.	Baby doesn't give up until he gets what he wants	1 2 3 4 5		Baby can be easily distracted if he doesn't get what he wants right away
3.	Baby is ahead of his age in physical activities like walking	1 2 3 4 5		Baby is slower than he should be at physical activities
4.	Baby loves other people	1 2 3 4 5		Baby generally distrusts other people
5.	I wish Baby were bigger(or smaller)	1 2 3 4 5		Baby's size is just right
6.	Baby eats way too much (or too little)	1 2 3 4 5		Baby's appetite is perfectly normal
7.	I wish Baby had nicer hair	1 2 3 4 5		Baby's hair is very nice
8.	Everybody notices my baby	1 2 3 4 5		People usually pay more attention to other babies than to mine
9.	Baby is too much for me to handle	1 2 3 4 5		Handling Baby is easy for me
10.	I know my baby will be very successful in life	1 2 3 4 5		I doubt that Baby will grow up to be anybody special
11.	Baby is very healthy	1 2 3 4 5		Baby's health is poor
12.	Baby is a lot smarter than other babies	1 2 3 4 5		Baby is not nearly as smart as other babies
13.	I dress my baby very nicely	1 2 3 4 5		Baby's clothes are not as nice as I'd like them to be
14.	I have an unusually noisy (or quiet) baby	1 2 3 4 5		Baby is normally noisy
15.	My baby is really beautiful (or good-looking)	1 2 3 4 5		Baby is not especially pretty (or good-looking)

*Adapted from Dr. Ira J. Gordon's HOW I SEE MYSELF SCALE for the Family Developmental Center by Paula Kleinfeld

16.	I wish Baby didn't cry so much	1 2 3 4 5	Baby's crying doesn't bother me at all
17.	Baby loves me more than anybody else in the world	1 2 3 4 5	I wish Baby loved me best
18.	I'm a lot better off now that I have my baby	1 2 3 4 5	Things would have been better for me if I didn't have Baby
19.	Caring for Baby takes up too much of my time	1 2 3 4 5	I'd rather spend my time caring for Baby than anything else
20.	Baby is darker (or fairer) complexioned than I like	1 2 3 4 5	Baby's coloring seems just right to me
21.	Watching a baby grow up is more exciting than anything	1 2 3 4 5	Bringing up a baby is kind of boring
22.	I don't really know much about babies	1 2 3 4 5	Baby care comes naturally to me